



Miami-Dade County Employee

Benefits

Your Benefits at a Glance

Medical, Dental, Life
and much more...

The Idea Machine

The Idea Machine is back

Last year, the County launched the Idea Machine and it was a phenomenal success. In the first 30 days after its launch, it received over 500 ideas from County employees. We are proud to announce the Idea Machine is back with new features to help empower County employees in this innovative process. With the new Idea Machine, it will be easier to submit and track your ideas -- and now you can even vote for and give feedback on your favorite ideas.

We want to hear from you! [Visit the Idea Machine](#) and submit your ideas today.

To login, you need your eKey (employee number is located on your badge). If you have forgotten your password, call the Help Desk at 305-596-4357.

Go green when you get your green!

Login now to view your pay stub.

Personalized

Employee Information

Payroll | Insurance | Leave | Pay stub

My Blue Book Info

New Hire Benefits Enrollment

Online Beneficiary Designation

General

General Store

Buy | Sell | Trade | Donate

Village News

Birthdays Today | County Anniversary Dates

Employee Discounts

Employee Eyes and Ears

Today's Headlines

Daily publications

Weekly publications

News

Be an EASY rider

Using Miami-Dade Transit will be easier than ever! The department is officially launching its new EASY Card automated fare collection system on Oct. 1. Passengers can now pay their fares with a reloadable card, which is already being accepted on all Metrobuses and most of the Metrorail system. Free EASY Cards are available at Metrorail stations, major bus transfer stops and select sales outlets -- but only for a limited time! Get all the details at the [Transit site](#).

Once banned, now remembered

Miami-Dade Public Library System is celebrating [Banned Books Week](#) during the [Freedom to Read](#) from Sept. 26 to Oct. 3 at all 48 branch libraries.

Go online and enroll at
<http://enet.miamidade.gov>



Employee Benefits Resource Directory

Miami-Dade County Benefits Administration Unit

Web Site

DPR Contact Information

On-Site Plan Representatives

Medical Plans

Onsite Representatives AvMed Health Plans

(Mon-Fri, 8:30a-4:30p)
305-375-5306

305-375-5633 or 305-375-4288

FAX 305-375-1368 or 305-375-1633

www.miamidade.gov/benefits

www.miamidade.gov/benefits (click **DPR listing** from left side)

Visit or call your on-site plan representative located in the Benefits Administration Unit, Stephen P. Clark Center, 111 NW 1st Street, Suite 2340, Miami, FL 33128

457 Deferred Compensation Plans

ICMA-RC	(Tues & Thurs, 9:00a - 4:00p)	305-375-4710
NRS	(Mon & Wed, 9:00a - 4:00p)	305-375-4853

Provider Addresses and Contact Information

MEDICAL

AvMed Health Plans
9400 S. Dadeland Blvd., Suite 420
Miami, FL 33156

Member Services 24/7
(800) 682-8633 or 800-68-AvMed
Fax (800) 926-4647
Nurse on Call 24/7
(888) 866-5432

TDD: (877) 442-8633
www.avmed.org/go/mdpht

JMH Health Plan
155 S. Miami Avenue, Suite # 110
Miami, FL 33130
(305) 575-3640
(800) 721-2993
www.jmhph.com

DENTAL

American Dental Plan (ADP)
100 Mansell Court East
Roswell, GA 30076
(800) 432-3376
(305) 262-1333
www.compbenefits.com

Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, GA 30023-1809
(800) 471-1334
<http://www.deltadentalins.com/mdc>

Oral Health Services
5775 Blue Lagoon Drive, Suite 400
Miami, FL 33126
(800) 432-3376
(305) 262-1333
www.compbenefits.com

VISION

Optix Vision Plan/Vision Care, Inc.
P.O. Box 30349
Tampa, FL 33630-3349
(800) EYE-CURE (393-2873)
www.compbenefits.com

OTHER

ARAG® Legal Plan
P.O. Box 93180
Des Moines, IA 50393-3180
(800) 667-4300
<http://members.ARAGgroup.com/MDCounty>

ICMA-RC
777 North Capitol Street, NW
Washington, DC 20002-4240
Local Phone: (305) 375-4710
Fax: (305) 569-0790
Investor Services: (800) 669-7400
www.icmarc.org/miamidade

NACo/Nationwide Retirement Solutions
21707 Altamira Avenue
Boca Raton, FL 33433
FL WATS (800) 432-0822
Fax: (561) 338-9731
Account Information (866) 986-4264
www.miamidade457.com

MetLife Disability
MetLife Disability Unit
P.O. Box 14590
Lexington, KY 40511-4590
(888) 463-2023; Fax *(800) 230-9531 or
(866) 690-1264
www.metlife.com/mybenefits

* When faxing information, include your name, SSN and/or claim # in the upper left hand corner of each page.

(overnight deliveries)
Metlife Disability c/o ACS
2025 Leestown Road, Suite A-2
Lexington, KY 40511
Phone: (859) 825-6486 (For delivery purposes)

Completed statements of health (evidence of insurability forms)/inquiries:
Statement of Health Unit
P.O. Box 14069
Lexington, KY 40512-4069
(800) 638-6420; FAX (859) 225-7909

Fringe Benefits Management Company (FBMC)
P.O. Box 1878
Tallahassee, FL 32302-1878
(800) 342-8017
Interactive Benefits 1-800-865-3262
www.myFBMC.com

The material contained in this Handbook does not constitute an insurance certificate or policy. This information provided is intended only to assist in the selection of benefits. Final determination of benefits, exact terms and exclusions of coverage for each benefit plan are contained in certificates of insurance issued by the participating insurance companies. Employees receive benefit certificates for those benefits selected.

Miami-Dade County Benefits Handbook

Table of Contents

2	Employee Benefits Resource Directory
4	Eligibility Requirements
5	Dependent Eligibility
8	Group Medical Dental and Vision Plans
10	Leave of Absence Q & A
11	Online Enrollment
13	Medical Plan Comparison
22	Dental Plan Comparison
24	Disability Income Protection
26	Flexible Spending Accounts
29	Healthcare FSA
31	OTC Category Reimbursement
32	Dependent Care FSA
34	FSA Worksheets
35	Changing Your Coverage
37	ARAG Legal Plan
40	Deferred Compensation
41	Group Term Life Insurance
42	COBRA Q&A
43	Disclosure Notice –SSN
44	Beyond Your Benefits
45	Important Notice About Prescription Coverage & Medicare
46	Health Benefits Notice of Private Practices

Visit www.miamidade.gov/benefits for the current biweekly employee rates and monthly COBRA premiums.

For employees without computer access, please contact your departmental personnel representative.

Web Access to Plan Information

Do you need a provider directory? Find a participating pharmacy, obtain a preferred drug formulary list? View your plan benefit summary or co-payments? Your health plan's Web site is a valuable resource for obtaining benefits information 24 hours a day, seven days a week. In addition to the "basics," here are the highlights of additional benefits available online:

AVMED (800) 682-8633 - www.avmed.org/go/mdpht

Print and request ID cards, view benefits, eligibility, co-pays, claims, authorizations, review prescription drug list, access the physician directory, access Transition of Care and Away From Home Forms. Complete a Health Report Card for suggestions on how to minimize health risks, plus much more.

JMH (305) 575-3640 - www.jmhhp.com: View Summary of Benefits (by product line), search for a provider in our Network (by specialty/zip code), check claims and authorization status, request a new ID Card, request a PCP change, view our Member Newsletter, access the Transition of Care & Away from Home forms, view the Prescription Drug List (PDL), get answers to your questions regarding Pharmacy benefits or specific medications via our link to Med Impact (our Pharmacy Benefit Management system), and email inquiries to our Member Services Department.

Delta Dental (800) 471-1334 www.deltadentalins.com/mdc: Find preferred dental providers, print an ID card, view your plan benefits, download a dental claim form, or find articles on oral health and wellness.

ADP & OHS (800) 432-3376 - www.compbenefits.com: Click "Customers", then click "Members", and then click on mycompbenefits to find participating dentist, specialists, request new ID cards, change providers and much more.

ARAG (800) 667-4300 (Legal and Senior Advocate Plans) - members.araggroup.com/MDCounty: Find a Network Attorney; view your benefit summary; learn how to best use your plan; download a claim form; use legal tools and resources, including the Law Guide, Do-It-Yourself Legal Documents™, the Legal Risk Assessment™ and the Legal Cost Calculator; send e-mail inquiries to the ARAG Customer Care Center, and much more.

MDC Benefits Website - www.miamidade.gov/benefits: Benefit forms can be accessed through this website. For example, Flex Benefits Change In Status (CIS) & Plan Status change forms, dental claim form, Optix Vision claim form, FSA Reimbursement form, disability claim form, evidence of insurability form (SOH) and many more.

Eligibility Requirements

Period of Coverage

Your period of coverage is the same as the plan year, January 1 through December 31 unless you terminate employment, reduce hours worked, go on an unpaid leave of absence, change your pre-tax benefit elections through a valid Change in Status or change your post-tax benefits.

Who is eligible for group benefits?

- Any full-time regular Miami-Dade County employee who has completed 90 days of employment is eligible. Coverage becomes effective the first of the month following or coincident to 90 days of employment, provided timely benefit elections are made online on the New Hire Benefits Enrollment, located on the eNet portal.
- Any part-time employee who consistently works at least 60 hours biweekly and has completed 90 days of employment is eligible. Coverage becomes effective the first of the month following or coincident to 90 days of employment provided timely election is made. The part-timer must continue to satisfy the minimum number of working hours requirement to remain eligible for benefits.
- Employees must be actively at work for disability or group life benefits to become effective.
- All employees are eligible to participate in the deferred compensation plan.
- Upon certain Qualifying Events, ex-spouses, children who cease to be dependents, employees going from full-time to part-time status and dependents of a deceased employee may be eligible for coverage under Consolidated Omnibus Budget Reconciliation Act (COBRA).
- Contact your DPR for questions regarding your eligibility for group medical, dental, vision, life insurance, disability and group legal, or to participate in a flex spending account.

New Employees

New hires become eligible for benefits on the 1st of the month following or coincident to 90 days of employment. All new employees must enroll for benefits directly online, through the County's eNet portal **New Hire Benefits Enrollment** link. Only new employees meeting the benefits eligibility criteria can access the enrollment website. To access the website, go to <http://enet.miamidade.gov> logon, then select the New Hire Benefits Enrollment link. Once the online benefits enrollment is completed, the employee is directed back to the eNet to complete the **Beneficiary Designation** information for their life insurance coverage. The online enrollment must be completed **before** the employee's benefits eligibility date (eligibility date = the 1st of the month following or coinciding with ninety (90) days of employment). The enrollment window is from the date the employee is added to the payroll system to the day before the benefits eligibility date. New hires are allowed a thirty (30) day grace period to enroll beyond their initial eligibility date. Coverage requested during the grace period will take effect the following 1st of the month. The Benefits Enrollment website is accessible from any computer 24/7.

New Hires with a benefits eligibility date of October 1 or earlier, will enroll for their initial benefits through the online New Hire Benefits Enrollment link, but must use the online Open Enrollment website (also on eNet) to re-enroll for a spending account or modify their plan elections for the following plan year. New hires with a benefits eligibility date of November 1 or December 1, cannot enroll on the Open Enrollment website. You must submit your benefits selections online through the County's eNet portal New Hire Benefits Enrollment link. Your new hire plan selections

for the current year will carryover into the next plan year. If enrolling in a spending account you will be required to select two (2) annual contribution amounts; one for the balance of the current year and a separate amount for the next plan year.

Special Enrollment Rights Pertaining to Medical Benefits

If you are declining enrollment for yourself or your dependent (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependent in your employer's plan provided that you request enrollment within **forty-five (45) days** after the other coverage ends.

Employees on Leave

If you participate in any of the benefits offered by Miami-Dade County and go on an approved leave of absence, or if you are in a "no-pay status" due to worker's compensation or suspension from work, it will affect your participation in the benefit plans. You are required to continue making payments to maintain insurance coverage. If you fail to submit payments, your coverage will be cancelled. Coverage may not be reinstated upon your return to work. Contact your Departmental Personnel Representative for detailed information. See the Leave of Absence Q&A section of this Benefits Handbook for further details.

Terminating Employees (Except Retirement)

All benefits end on the last day of the pay period in which the termination date falls and for which the employee experiences a regular insurance deduction or made a direct payment to the Benefits Administration Unit (if on an unpaid leave of absence).

- Health & Life Insurance - You will receive instructions by mail from the medical, dental and vision insurance carriers regarding continuation of existing coverage (COBRA). You have sixty (60) days to elect coverage continuation. **Refer to page 42 for additional COBRA information..** Life insurance is not subject to COBRA, however, basic and/or optional life coverage may be converted to an individual policy at the prevailing rates. The life insurance information will be mailed to you. You have the later of, thirty (30) days from termination, or fifteen (15) days from notice, to elect the conversion policy.

If you are a terminating employee, you can continue certain benefits by contacting the following providers within 60 days of your termination of employment:

- FBMC Customer Care Center at 1-800-342-8017 to apply for continuation, on an after-tax basis, of your Healthcare FSA. If you elect to continue your Healthcare FSA through COBRA, you can be reimbursed for expenses incurred through the end of the plan year (December 31) or until you exhaust your account balance. If you choose not to continue your Healthcare FSA through COBRA, you can only be reimbursed for expenses incurred within your period of coverage. NOTE: Your employer's Healthcare FSA Plan is not subject to COBRA continuation beyond the end of the plan year in which a COBRA-qualifying event occurs. Dependent Care FSA cannot be continued.
- You may contact ARAG directly if interested in purchasing a group legal conversion policy. Note, the plan benefits and rates may differ under a conversion policy.

Dependent Eligibility

Who are Eligible Dependents?

If you enroll for medical, dental, vision, or group legal, you may also cover your eligible dependents by selecting dependent coverage under those options, when you enroll online. Outside of the open enrollment period, dependents may be added/cancelled only if you experience a mid-year qualifying event. Refer to page 36 for further information. Eligible dependents include:

- Your spouse or Domestic Partner (DP) unless also an eligible County or Public Health/Jackson Health System employee. Eligible employees are not allowed to cover each other on their group medical or dental plan. Ex-spouses may not be enrolled for group benefits under any circumstances.
- Your unmarried natural child (including a newborn), stepchild, child of a domestic partner, foster child, adopted child (including a newborn child who is required to be eligible for membership as an adopted child in conformity with applicable law) or a child for whom the employee has been appointed legal guardian, pursuant to a valid court order, and the child is under the limiting age. The eligibility limiting age of an unmarried dependent child is the end of the calendar year in which the child reaches age 19. Coverage (except for Foster children in court-ordered custody or guardianship of the employee) may be extended until the end of the calendar year in which the dependent child reaches age 25, if all of the following requirements are met: a.) the unmarried child is primarily dependent upon the employee for financial support and b.) the unmarried child is living in the household of the employee or the unmarried child is a full-time or part-time student. Coverage may be continued beyond age 25 through age 30 (end of calendar year), refer to section below regarding dependents age 25 to age 30.

Employees are required to provide the health plan by December 1 acceptable documentation that the child meets and continues to meet such requirements. Failure to provide acceptable documentation will result in cancellation of the dependent's medical, dental, vision coverage (if enrolled). Acceptable proof that the child continues to meet the financial dependent eligibility criteria beyond age 19 may include:

- a.) Affidavit of Support and
- b.) proof of student status or
- c.) proof the child resides in your household.
- Dependent children who are incapable of sustaining employment because of mental or physical disability, and are dependent upon the employee for support, may continue to be covered beyond the limiting age, providing the child was enrolled prior to age 25. Proof of disability must be submitted to the health plan each year on an ongoing basis.

Dependents Age 25-30 (FSS 627.6562)

Medical coverage may be extended beyond the limiting age of 25 (to end of the calendar year the child turns 30), if the child meets the following conditions: 1) The child is unmarried and does not have any dependents of his/her own. 2) The child is a resident of the state of Florida, or a full-time/part-time student. 3) The child is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act. The extension applies to medical coverage only.

Although the Florida statute gives employers the option of charging a higher premium for dependents age 25+ through age 30, the County elected not to do so at this time. However, the County reserves the right to exercise this option in future years. Based on IRS rules, the premiums for dependents age 25+ through age 30 must be deducted on a post-tax basis and subject to imputed income tax. Go to www.miamidade.gov/benefits for additional information regarding the post-tax premium breakdown and imputed income tax.

Domestic Partners (DP) Information

County benefit plans that are otherwise available to an employee's spouse and dependent children (medical, dental, vision, and group legal plan) are available to domestic partners (DP) and their dependent children. This provision applies to both same sex and common law relationships. DP's and their children are not eligible for expense reimbursement through a healthcare or dependent care spending account.

To enroll a domestic partner (DP) in a County-sponsored benefit plan, the employee and DP must first file a declaration of domestic partnership with the Miami-Dade County Department of Consumer Services to obtain a Certificate of Domestic Partnership. The employee may add the domestic partner (and/or children of the domestic partner) within forty-five (45) days of the qualifying event, using the Health Plan Status Change form; attach the domestic partnership certificate, plus the birth certificates of DP's dependent children to be enrolled. Once the eligibility period lapses, the employee will have to wait until the annual open enrollment to submit the benefit selections online. Refer to page 7 for dependent documentation requirements. The deadline to submit documentation for dependents enrolled during the open enrollment is December 1, to assure timely receipt of the insurance ID cards.

Mid-Year Status Changes

For mid-year family status changes, the date the partnership is registered or terminated with the MDC Consumer Services Department will be the start of the 45-day eligibility period. The benefits enrollment or deletion of dependents must be completed during the 45-day eligibility period. The premium change, if any, will be effective the 1st day of the pay period following receipt of the status change form by the Benefits Administration Unit.

Dependent Eligibility

Dissolution of Domestic Partnership

Domestic partners and their dependents must be dropped from County insurance plans upon termination of the domestic partnership. Group benefits end as of the date the domestic partnership termination certificate is issued. The certificate issued by the MDC Consumer Services Department declaring the termination of the domestic partnership must be presented to the Benefits Administration Unit within 45-days of issuance, along with the Change in Status form cancelling the DP and dependents. The premium change, if any, will be effective the 1st day of the pay period following receipt of the Change in Status form by the Benefits Administration Unit. Be aware that under the domestic partnership benefits ordinance, any employee who obtains or attempts to obtain benefits fraudulently under this provision (including continuing insurance coverage for ineligible individuals after the dissolution of a domestic partnership) shall be subject to discipline, up to and including termination.

Premiums

Please note that under current IRS rules, insurance premiums for a DP and/or DP's children must be deducted on a post-tax basis and subject to imputed income tax, unless the domestic partner/dependents qualify as the employee's tax dependent. The IRS rules prohibit changing premiums mid-year from pre-tax to post tax (as well as the reverse). An example of this would occur when an employee's enrollment level is "Employee + Child(ren)" covering his/her natural child (or children), then acquires a child of a domestic partner (DP) during the year. The entire dependent child premium would now become post-tax, due to the addition of the DP's child. However, since the IRS rules prohibit changing premiums mid-year from pre-tax to post-tax (and post to pre-tax), the employee would have to wait until the next open enrollment to add the DP's child.

Imputed Income

The Internal Revenue Service allows the employee to receive "tax free" health insurance subsidies for themselves and their eligible dependents as defined under IRS guidelines, but excludes those amounts attributable to coverage of a domestic partner (DP) and/or dependents of a domestic partner. In light of this, the County must include the fair market value of DP benefits in the employee's income, referred to as "imputed income" and this imputed income will be taxed accordingly. Go to www.miamidade.gov/benefits for information regarding the post-tax premium breakdown and imputed income tax. Please consult with a financial planner or tax consultant to see how that impacts your particular situation.

Domestic Partner (DP) - Continuation of Coverage

Coverage continuation under COBRA law is not available to Domestic Partners and their dependents. However, if the insured DP (and/or dependents) experience a qualifying event due to the employee's termination of employment or reduction of hours, continuation of group health, dental and/or vision coverage will be allowed for a period of up to 18 months. Continuation up to 36 months will be allowed for events such as death of the employee, the employee's entitlement to Medicare, dissolution of the domestic partnership registered with Miami-Dade County. Continuation depends on the timely payment of premiums. It is the responsibility of the employee or DP to notify the Benefits

Administration Unit in writing within 45 days, of the loss of eligibility and to apply for continuation of benefits. Supporting documentation is required.

Is coverage guaranteed?

During Open Enrollment eligible employees and their dependents are guaranteed enrollment in any of the County-sponsored medical plans. Eligible new hires and their dependents are also guaranteed coverage in any of the County-sponsored medical plans if they enroll during their initial eligibility period. Coverage is also guaranteed if you enroll yourself and/or your dependents within **45 days** of a Change In Status (60 days for newborns, adoption\placement for adoption), or if you qualify under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). See the Changing Your Coverage section for more information on Changes In Status and HIPAA.

For additional information on medical plans, refer to your Benefit Comparison Chart included in this Benefits Handbook, visit the plans' website or contact the plans directly at the numbers provided for information specific to your needs.

Dependent Eligibility

Dependent documentation required by Health Plans.

The health plans will continue to screen for the eligibility of dependents with last names that differ from yours and for the eligibility of dependent children beyond the limiting age of 19 years. This process will help us ensure that ineligible dependents are not being covered, and costing the plan (and you) money. It is your responsibility to provide the health plans with the required documentation by December 1. New employees enrolling for benefits during their initial eligibility must submit the dependent documents to the health plan no later than their benefits eligibility date. Please obtain proof of mailing or fax sent to the plans. Also, remember the onsite representatives and your DPR will accept proof of dependent eligibility. Failure to provide the information will jeopardize the coverage of your dependent(s).

Type of Documentation Required by Dependent Type

Spouse	Copy of official certified or registered Marriage Certificate (religious certificates are not acceptable)
Domestic Partner	Copy of the domestic partnership certificate issued by the MDC Consumer Services Department
Child(ren) of Domestic Partners	Copy of official Birth Certificate(s) showing employee's Domestic Partner as parent (birth cards are not acceptable) and copy of the domestic partnership certificate issued by the MDC Consumer Services Department
Child(ren)	Copy of official Birth Certificate(s) showing employee as parent (birth cards are not acceptable)
Stepchildren	Copy of official Birth Certificate(s) AND copy of official State certified or registered Marriage Certificate
Child(ren) under Legal Guardianship, Custody or Foster Care	Copy of Legal Guardianship/Custody document from the Courts or copy of Foster Care documentation from Courts.
Child(ren) adopted or child(ren) in the process of adoption	Copy of Legal Adoption documentation showing relationship to employee and placement in employee's home or copy of Adoption Certificate issued through the Courts.
*Grandchild(ren) OR other child not related	Copy of official Birth Certificate(s) of child(ren) AND copy of Legal Guardianship, Adoption or Foster Care document from the Courts.

* A dependent of a dependent (child born to an enrolled child dependent) may remain on the plan for up to 18 months from the date of birth. After 18 months, the grandchild must meet the criteria of legal guardianship by the employee, spouse or domestic partner.

Additional Documentation Required For All Dependent Children Age 19 or Older

Mid-Year Status Changes

The following documentation is also required to add a new dependent child age 19 or older, or to continue coverage for an existing covered dependent child above age 19. Employees are required to submit the documentation listed below every year, before the start of the plan year.

Children age 19 - 25 (Turning 25 by December 31)

Eligibility: 1) The unmarried child is primarily dependent upon the employee for financial support, and 2) Living in the employee's household or is a full-time or part-time student.

Documents: 1) Income Tax Filing or Affidavit of Support and 2) Proof the child resides in your household (e.g. child's driver's license showing address is the same as employee's), or proof of student status

Children age 25+ to 30 (Coverage ends December 31 of year dependent turns age 30)

Eligibility (FSS 627.6562: 1) The unmarried child does not have any dependents of his/her own. 2) Is a resident of the state of Florida, or a full-time/part-time student. 3) The child is not provided coverage or is a covered person under any other group health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act. The extension applies to medical coverage only.

Documents: 1) Affidavit of Eligibility and 2) proof of student status, or proof of Florida residency (e.g. child's driver's license, etc.).

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. F.S. Section 817.234 (1) (b) (2000)

Group Medical, Dental and Vision Plans

Group Medical Plan

As an eligible Miami-Dade County employee, you may choose from five different medical plans:

- **AvMed Point of Service (POS)** (AvMed encourages but does not require the selection of a primary care physician (PCP). No referrals are required to receive covered medical services from participating specialists).
- **AvMed High Option HMO** (AvMed encourages but does not require the selection of a primary care physician. No referrals are required to receive covered medical services from participating specialists).
- **AvMed Low HMO** (Employees are required to select a PCP for each person to be enrolled. Referrals from the PCP are required to receive covered medical services from participating specialists).
- **JMH High Option HMO** (JMH encourages but does not require the selection of a primary care physician. No referrals are required to receive covered medical services from participating specialists).
- **JMH Low Option HMO** (Employees are required to select a PCP for each person to be enrolled and referrals are required to receive covered medical services from participating specialists).

A Point of Service (POS) plan allows you to receive services from an in-network or out-of-network provider of your choice. If you choose an out-of-network physician, your healthcare services will be subject to the plan deductible and co-insurance provisions.

A Health Maintenance Organization (HMO) provides a wide range of healthcare services to you on a prepaid basis. Under this plan, you receive medical services at no cost or for moderate co-payments without deductibles or claim forms.

Union Plan: Members of the DCFF fire union may be eligible for coverage in their Union-sponsored plan. Contact your Union office for further details.

Group Dental Plan

You may enroll yourself and your eligible dependents for dental coverage even if you don't elect medical coverage. You may choose the plan that best suits your needs:

- Delta's Standard or Enriched Dental Indemnity plan
- American Dental Plan's Standard or Enriched Dental prepaid plan
- Oral Health Services' Standard or Enriched Dental Prepaid plan
- **Indemnity:** Standard or Enriched. Select the dentist of your choice. Benefits are payable at various coinsurance levels. A deductible is applied for services other than preventive and diagnostic. Annual maximum reimbursements are: \$1,000 per person for the Standard plan and \$1,500 per person for the Enriched plan. The Enriched plan also includes orthodontia.
- **Prepaid:** Standard or Enriched. Choose a plan dentist from a list of participating dentists and receive coverage for a variety of services.

Participating dentists are primarily in the South Florida Tri-county area. Most preventive, diagnostic and many other services are provided at no additional cost to members. Some services have fixed co-payments. There are no claim forms, no deductibles and no annual dollar maximum under the prepaid dental programs. The Enriched Prepaid Dental plan provides additional benefits and specialty coverage not covered under the Standard program.

Services must be received by a participating provider within the plan's service area.

Group Vision Plan

VisionCare, Inc. (VCI), a subsidiary of CompBenefits, offers the Optix prepaid vision plan to all employees eligible for medical and dental coverage regardless of union affiliation. Employees pay the full cost of the program. You and your enrolled dependents, if any, will receive an annual comprehensive eye exam at no charge with a participating optometrist or ophthalmologist. Members may also receive a pair of glasses every year, with a \$10 copay, from a special selection of frames available at participating providers. Contact lenses or other frames are available as alternate benefits. This program allows you to use non-participating providers and be reimbursed according to the non-participating benefit schedule. See the Optix plan literature for plan benefits, limitations and rates.

Please see page 5 for dependents eligible to participate in group medical, dental and vision benefits.

What you can expect:

- Immediate savings
- Convenient locations
- Quality professional care and services
- No complicated forms to fill out
- No long waits for rebates
- Out-of-network benefits

Get More Information

For more about this plan and how it works, get in touch with Optix by calling the toll-free number: 1-800-EYE-CURE.

Union Plan

If you are enrolled in the DCFF Fire Union-sponsored health plan, you may elect coverage through the Optix vision plan, but you cannot participate in any County-sponsored dental program. Contact the DCFF Union Office for health coverage information and dependent eligibility.

Insurance Rates

Visit www.miamidade.gov/benefits for current biweekly rates.

Group Medical, Dental and Vision Plans

Is coverage guaranteed?

You are guaranteed group medical, dental and group vision coverages as long as you enroll during Open Enrollment, during your initial eligibility period, within **45 days** of a Change In Status (60 days for newborns, adoptions\placement) , or if you are qualified under HIPAA.

For additional information on medical\dental plans, refer to the Benefit Comparison Chart in this booklet or contact the plan.

For additional information on Optix vision benefits, refer to the Optix Plan literature, or contact the plan.

If you have medical, dental or vision coverage, your co-payments or uninsured out-of-pocket expenses may be eligible for reimbursement through your Healthcare FSA. See Page 30 for a partial list of eligible expenses or call FBMC Customer Care Service Center at 1-800-342-8017.

Former MetLife Dental Plan Enrollees

This dental plan will be terminated as of December 31, 2009. All dental claims incurred through that date must be submitted to MetLife for review and processing as soon as possible, but no later than December 31, 2010. Claims received by MetLife after December 31, 2010 may not be processed and you may be held financially responsible. Submit MetLife claims to:

**MetLife
Dental Claims Unit
P.O. Box 981282
El Paso, TX 79998-1282**

Report Address Changes

The County's benefit providers experience an ongoing problem receiving numerous returned mail due to incorrect employee addresses. To guarantee that important information is properly delivered to you (such as the FRS Annual Member Statements, Medical Plan Claim Explanation of Benefits, insurance ID cards, summary plan descriptions, etc), please assure your address is updated in the County's payroll records. Remember to promptly advise your department personnel representative (DPR) of any change in your address so they may update the payroll records.

Leave of Absence Q&A

What is the cost to maintain group benefits while on an approved Leave of Absence (LOA) without pay?

The premium you are responsible for depends on the type of leave. If your leave is illness related (i.e. Family Medical Leave (FMLA), disability, worker's compensation, maternity etc.), you will only be responsible for paying the bi-weekly insurance contributions that are usually withheld from your paycheck. If your leave is other than illness related (i.e. educational, suspension, personal, etc.), you will be responsible for paying both the biweekly employee and County contributions. Your Department Personnel Representative (DPR) will provide you with an LOA information package, billing notice and remittance form. Contact your DPR for additional information related to military leave.

When are Leave of Absence payments due?

Your DPR will provide you with a leave of absence package which explains what needs to be done to maintain your insurance while on leave, if you so choose. It also includes instructions on where payments must be sent. The first payment is due within two weeks of your last payroll deduction for benefits. Thereafter, premium payments are due bi-weekly in advance of the pay period to be covered. If coverage is cancelled due to non-payment of premiums when due, you will only be allowed to re-enroll during the next annual open enrollment period. Please follow-up with your DPR to receive this information when on an approved LOA.

If dependent premiums become a financial hardship, may I delete my dependent(s) from my health insurance while on an approved leave without pay status?

Yes. You may delete your dependent(s) while on an approved leave without pay by submitting a completed Flexible Benefits Change in Status Form and Insurance Status Change Form. You must submit these forms to your DPR within **45 days** of being in a no-pay status.

May I temporarily cancel my health insurance while I am on an approved leave of absence?

You may submit a completed Flexible Benefits Change in Status Form and Insurance Status Change form within **45 days** of being in a leave without pay status to temporarily cancel your health insurance coverage. Upon return to pay status (within **45 days**), you must re-submit a completed Flexible Benefits Change in Status form and Insurance Status Change Form to your DPR to reinstate coverage.

What is the process to report a change in family status?

Contact your DPR to obtain the Flexible Benefits Change in Status Form and the Insurance Status Change Form (or download from www.miamidade.gov/benefits), if you experience a family status change (adding newborn, divorce, etc.). Submit the forms to your DPR within 45 days of the event (60 days for newborns, adoption\placement for adoption). If the status change results in a premium adjustment, contact your DPR to determine the cost, or go to www.miamidade.gov/benefits for the current employee biweekly rates. Follow-up with your DPR if you don't receive a revised LOA billing notice. Don't delay the payment for this reason, otherwise you risk having your coverage cancelled for non-payment. It is the employee's responsibility to submit the insurance payments in a timely manner and for the correct amount.

Enrollment on the Web

Online Benefits Enrollment

New employees eligible for County health and flexible benefits must enroll directly online. The online process is simple. No long forms to fill out or need to worry about paperwork getting misplaced. No guessing what your payroll deductions will be. Register online and it will be calculated for you. All you need is 15 to 20 minutes of uninterrupted time to make your elections.

Enroll using the New Hire Benefits Enrollment link, located on the eNet portal. After submitting your benefit plan selections, you will be prompted to continue to the Online Beneficiary Designation in connection with your life insurance coverage. Enter your designated beneficiaries for your basic life insurance death benefits. If you elected optional life insurance coverage, enter your beneficiaries in the Optional Life section. Save each entry. Remember that your beneficiary information will not be saved and the document will not be registered, until you click on the "Submit All Changes" button. Print your life insurance beneficiary designation confirmation page and retain with your important documents.

The New Hire Benefits Enrollment website can be accessed from any computer 24/7, but only during your eligibility period. Enrollment Window –The enrollment window starts on the date you are active in the payroll system, to the day before your benefits eligibility date. Your benefits eligibility date = the 1st of the month following or coinciding with ninety (90) days of employment. Contact your Department Personnel Representative (DPR) if you have any questions regarding your benefits eligibility. The Online Beneficiary Designation link can be accessed 24/7 and you may change beneficiaries at any time during the year.

Before You Start

Make sure you thoroughly review your enrollment materials. Most of these documents are online. If, after reviewing the materials, you still have questions, contact the plan directly or your Department Personnel Representative (DPR). Make sure you have the following information handy:

- **Employee Identification Number (Miami-Dade eKey)** - This 8-digit number can be found on the upper left corner of your pay stub or in most cases, your employee photo ID. You'll also need to know the last 4 digits of your social security number the first time you log on to eNet.
- **Primary Care Physician Number (for you and dependents)** - if enrolling in the AvMed or JMH Low Option HMO Plans.
- **Participating Dentist Number** - if changing to ADP or OHS or adding new dependents.
- **Dependent Information** – This includes names and dates of birth for all eligible dependents being enrolled. Also, indicate if dependent is covered by another group medical plan, for coordination of benefits (COB) purposes.
- **Spending Accounts**- Annual amount you wish to contribute.

Logging On

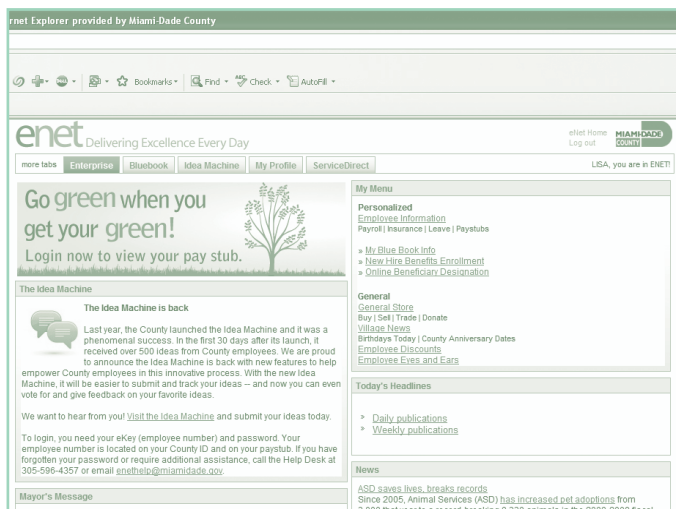
Online enrollment is a 12-step process that must be completed in one session. If you log off before completing the final step, you will not be able to return to the place where you left off. Your changes will not be saved unless you press the Complete Enrollment button in Step 12. So, please be sure you have the 15 to 20 minutes it takes to complete all the steps.

1. Go directly to <http://enet.miamidade.gov>.

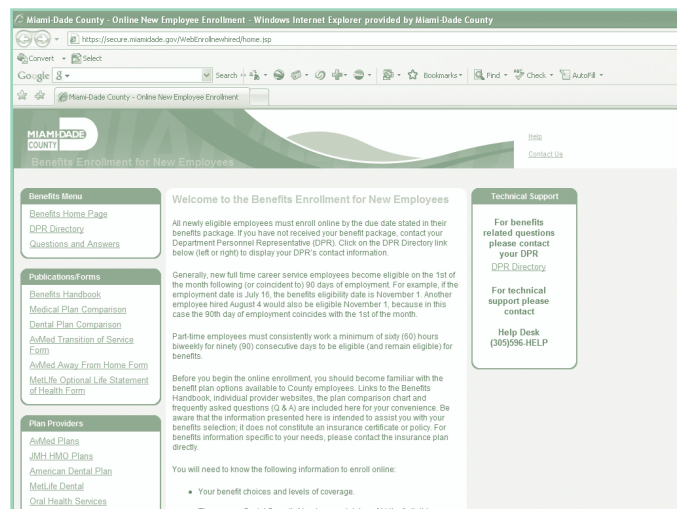
First time eNet users will be required to set-up an account and create a password. To begin, your Miami-Dade e-Key is the combination of the letter "e" and your employee payroll ID#. First time eNet users, your initial password will be "Pass" plus last 4 digits of your Social Security number (example Pass1234). Click the Login button. First time users, you will be required to change your initial password (to a different one). Follow the instructions on the screen to change password. Click "Change Password" and login to eNet using your newly created password.

Not a first time eNet user? Enter e-Key and your eNet password and click Login button. Forgot your password? Click "Forgot Password" and follow the instructions to reset it. Contact the Help Desk at 305-596-Help, if you experience technical difficulties.

Enrollment on the Web



2. On the next screen, click New Hire Enrollment link in My Menu to begin the enrollment process



3. Review the information on the screen, then click the “Begin Enrollment” button. Remember that your benefits elections will not be saved until you click the “Complete Enrollment” button in Step 12. Print your online confirmation notice, as verification of enrollment.

Beneficiary Change Form - Windows Internet Explorer provided by Miami-Dade County

GROUP LIFE AND OPTIONAL LIFE ENROLLMENT AND BENEFICIARY DESIGNATION FORM

GROUP NO: 00101 - LIFE0000

Employee Name	Social Security Number	Employee Status	Date of Birth	Employment Date
DALE Last First MI	000,000,000	AC	01/01/1980	01/01/1980

GROUP LIFE INSURANCE

Primary Beneficiary Designation

Present 101 to be made in full (blank or 0) in the absence of any other designation

ENR Details	First Name	Middle Initial	Last Name	Relationship	Date of Birth	SSN	Address	City	State/Province	Country	Zip Code/Postal Code	Share %
ENR 00000	LUCE		DALE	00000000	01/01/1980	000,000,000	428 SW 12 AVE	MIAMI	FL	USA	33170	100.00
Total												100.00

Add Group Life Primary Beneficiary

In the event you add primary beneficiary(ies) predecessor(s) (or, designate as contingent beneficiary(ies))

Present 101 to be made in full (blank or 0) in the absence of any other designation

ENR Details	First Name	Middle Initial	Last Name	Relationship	Date of Birth	SSN	Address	City	State/Province	Country	Zip Code/Postal Code	Share %
ENR 00000	LEVY		DALE	00000000	01/01/1980	000,000,000	428 SW 12 AVE	MIAMI	FL	USA	33170	00.00
ENR 00000	TONY		DALE	00000000	01/01/1980	000,000,000	428 SW 12 AVE	MIAMI	FL	USA	33170	00.00
Total												100.00

Add Group Life Contingent Beneficiary

I agree to be insured as indicated by submission of this form, until further notice for the Group Life Insurance, Accidental Death and Dismemberment Insurance, and Optional Life Insurance indicated and described in my Employer's current group policy issued by the current Group Center or as amended. I hereby authorize my Employer, and further notice, to deduct from my pay contributions to the cost of such insurance. Further, I understand that if this application is renewed after 30 days of initial eligibility for such coverage, evidence of insurability will be required by the current Group Center and is subject to medical approval. I must be actively at work for coverage to remain in effect.

I agree/consent the above statement: ☐ Yes ☐ No

YOUR BENEFICIARY INFORMATION WILL NOT BE SAVED UNTIL YOU AGREE TO THE PREVIOUS STATEMENT AND CLICK THE SUBMIT ALL CHANGES BUTTON

4. You will then be prompted to the Online Beneficiary Designation link. Save each beneficiary entry. Remember that your beneficiary information will not be saved and the document will not be registered, until you click the “Submit All Changes” button. Print your life insurance beneficiary designation confirmation page and retain with your important documents.

What's Online

Everything you need for online Open Enrollment can be found on the Open Enrollment Web site including:

- Benefits Handbook
- Links to provider Web sites
- Medical Plan Comparison
- Dental Plan Comparison
- Department Personnel Representative Directory
- Frequently Asked Questions (FAQs)

Need Technical Help

Call 305-596-HELP.

AVMED (POS) Plan

AVMED HEALTH PLANS (POS) (This Plan Allows You To Use Both In And Out Of Network Providers. For Purposes Of This Summary, The Two Will Be Discussed Separately.) Visit our website at www.avmed.org/go/mdpht		
COVERAGE PLAN DESCRIPTION	IN NETWORK	OUT OF NETWORK
	AvMed offers Miami-Dade County employees, covered dependents and retirees under age 65 "no referral" access to an expanded network of providers in the state of Florida. In addition, AvMed offers a nationwide network for those residing outside of the service area. The plan provides 100% benefits for covered charges, after applicable co-payments. Members are encouraged, but not required, to select a primary care physician. AvMed offers 24 hour Member Service, 24 hour Nurse on Call hot lines, discounted health and wellness programs, "Healthy Living" and care management programs personalized to improve the member's health, discounted Mail Order Prescriptions and more.	A fee for service program that provides you the freedom to use any physician or accredited hospital of your choice outside of the network. Payments are based on reasonable and customary (R & C) charges. Providers who do not participate in the network may balance bill you for the amount which exceeds R & C. Coverage is subject to deductibles and co-insurance.
DEDUCTIBLES/ COPAYMENTS	Co-payments \$10 Physician office visit /services 100% Hospital admission coverage - no copay \$50 Emergency Room (waived if admitted) \$5/\$10/\$15 Prescriptions for 30 day supply Mail Order: \$10/\$20/\$30 for 90 day supply.	Deductible \$200 per individual; \$500 per family Max out-of-pocket limit is \$1500 per individual (not including deductible) \$50 Emergency Room Co-payment (waived if admitted) Same in-network prescription benefits apply if participating pharmacy is used. Benefits payable at 70% of reasonable & customary (R & C) after deductible is met.
PHYSICIANS	Access any primary care physician or specialist from the Elite Access Network. Members are encouraged but not required to select a primary care physician. Covered family members may choose their own primary care physician.	Choose any licensed physician; covered charges payable at 70% of reasonable & customary (R & C) after deductible is met.
A. IN-HOSPITAL PHYSICIAN SERVICES: Surgery/Visits & Consultations Anesthesiologist B. OUT-PATIENT PHYSICIAN SERVICES: Office visits for illness Office visits for injury Diagnostic X-Rays, Lab Tests, X-Ray treatments Pediatrician 1) Medically Necessary 2) Preventive (Child Health Supervision Services) Routine Physical Obstetrical/Gynecological	Benefits payable at 100% when received at participating hospitals and rendered by participating physicians. \$10 co-payment; then 100% \$10 co-payment; then 100% 100% \$10 co-payment; 100% thereafter. \$10 co-payment; then 100% Covers Child Health Supervision Services up to age 15. \$10 co-payment; then 100% \$10 co-payment; then 100%. Mammograms, PAP smears payable at 100%. Maternity Care: \$10 co-pay for 1st visit, 100% thereafter.	Benefits are payable at 70% of reasonable & customary (R & C) covered charges, after deductible is met. Plan pays 70% of R & C covered charges, after deductible is met. Plan pays 70% of R & C covered charges, after deductible is met. Plan pays 70% of R & C covered charges, after deductible is met. Plan pays 70% of R & C covered charges, after deductible is met. 100% of R & C covered charges, no deductible. Covers Child Health Supervision Services through age 15. Not covered Plan pays 70% of R & C covered charges, after deductible is met.

AVMED (POS) Plan

AVMED HEALTH PLANS (POS) (This Plan Allows You To Use Both In And Out Of Network Providers. For Purposes Of This Summary, The Two Will Be Discussed Separately.) Visit our website at www.avmed.org/go/mdpht		
Hospitalization:	Benefits payable at 100% at following affiliated hospitals when admitted with PCP authorization: MIAMI-DADE COUNTY Anne Bates Leach Eye Hospital • Aventura • Baptist • Coral Gables • Doctor's Hospital • Hialeah Hospital • Homestead Hospital • Jackson Memorial Hospital • Jackson South Community Hospital • Jackson North Medical Center • Kendall Regional Medical Center • Larkin Community Hospital • Mercy Hospital • Miami Children's • Mt. Sinai Medical Center • North Shore Medical Center • Palmetto General • Select Specialty Hospital • South Miami Hospital • University of Miami Hospital & Clinics BROWARD COUNTY Anne Bates Leach Eye Hospital • Broward General Medical Center • Cleveland Clinic Hospital • Coral Springs Medical Center • Holy Cross Hospital • Imperial Point • Joe Di Maggio Children's Hospital • Memorial Regional Hospital • Memorial Miramar • Memorial Pembroke • Memorial Hospital South • Memorial West • North Broward Medical Center • North Shore Medical-FMC • Northwest Medical Center • Plantation General • University Hospital • Westside Regional Medical Center	Plan pays 70% of R & C covered charges, after deductible is met.
Hospital/Surgical Requirements: Precertification of hospital confinements	Handled by admitting physician.	Precertification required or benefits will result in a \$500 penalty. This is the responsibility of the member, not the providers.
Drug & Alcohol Treatment: Inpatient Outpatient	No charge \$10 per visit	Benefits payable at 70% of R & C, after deductible is met. * Benefits payable at 70% of R & C charges after deductible is met. *
Mental & Nervous Disorders: Inpatient Outpatient	No charge \$10 per visit	Benefits payable at 70% of R & C, after deductible is met. * Benefits payable at 70% of R & C charges after deductible is met. *
Ambulance Vision	100% when medically necessary Coverage provided for diseases of the eye and/or injuries to the eye. Eye exams for children under age 18 covered 100%, after \$10 co-payment. AvMed offers adult vision discounts through a preferred network of providers listed in the Provider Directory. Eye exams, glasses, contact lenses not covered.	100% when medically necessary Coverage provided for diseases of the eye and/or injuries to the eye at 70% of R & C after deductible is met. Eye exams, glasses, contact lenses not covered.

AVMED (POS) Plan

AVMED HEALTH PLANS (POS) (This Plan Allows You To Use Both In And Out Of Network Providers. For Purposes Of This Summary, The Two Will Be Discussed Separately.) Visit our website at www.avmed.org/go/mdpht		
Prescription Drugs:	\$5 Generic/\$10 Preferred Brand/\$15 Non-Preferred Brand prescriptions for 30 day supply including prescription contraceptives at participating pharmacies nationwide. See plan literature for participating pharmacies. Mail order: 2x co-pay for 90-day supply.	\$5 Generic/\$10 Preferred Brand/\$15 Non-Preferred Brand prescriptions for 30 day supply including prescription contraceptives at participating pharmacies nationwide. Mail order: 2x co-pay for 90-day supply. See plan literature for participating pharmacies. Plan pays 70% after deductible at non-participating pharmacies.
Durable Medical Equipment (DME):	Covered at 100%.	70% of R & C charges after deductible is met.
Autism Spectrum Disorder (Includes: Autistic Disorder, Asperger's Syndrome & Pervasive Development Disorder):	Physical, speech, occupational therapy \$10 per visit Applied Behavior Analysis \$10 per visit Coverage for the diagnosis and treatment of Autism Spectrum Disorder includes Physical Therapy, Speech Therapy, Occupational Therapy and Applied Behavior Analysis. Coverage is limited to \$36,000 annually and may not exceed \$200,000 in total lifetime benefits.*	70% of R & C charges after deductible is met. Coverage for the diagnosis and treatment of Autism Spectrum Disorder includes Physical therapy, Speech therapy, Occupational Therapy and Applied Behavior Analysis. Coverage is limited to \$36,000 annually and may not exceed \$200,000 in total lifetime benefits.
Out of Area: 1) Emergency 2) Non-Emergency	\$50 co-pay, waived if admitted/100% thereafter. Out of network applies: 70% of R & C charges after deductible is met.	\$50 co-pay, waived if admitted/100% thereafter. 70% of R & C charges after deductible is met.
*This comparison is not a contract. For specific information on benefits, exclusions and limitations, please see the Summary Plan Description. Maximum lifetime benefits is unlimited in-network, \$1 million out-of-network. Out-of-network annual out-of-pocket maximum is \$1,500 per individual (no family maximum) and applies to most services. Non-participating out-of-network providers have not agreed to accept AvMed's reasonable and customary standard (R & C) as payment in full for covered services. Therefore, if a non-participating provider is used the member is also responsible for the difference between R & C and the non-participating provider's actual charges.		

AVMED & JMH HIGH OPTION (HMO) Plans

	AVMED HEALTH PLANS HIGH OPTION (HMO) Visit our website at www.avmed.org/go/mdpht .	JMH HEALTH PLAN HIGH OPTION (HMO) Visit our website at www.jmhnp.com
COVERAGE PLAN DESCRIPTION	AvMed offers Miami-Dade County employees, covered dependents and retirees under age 65 "no referral" access to an expanded network of providers in the state of Florida. In addition, AvMed offers a nationwide network for those residing outside of the service area. The plan provides 100% benefits for covered charges, after applicable co-payments. Members are encouraged, but not required, to select a primary care physician. AvMed offers 24 hour Member Service, 24 hour Nurse on Call hot lines, discounted health and wellness programs, "Healthy Living" and care management programs personalized to improve the member's health, discounted Mail Order Prescriptions and more.	An Open-Access, "no-referral" managed care program which offers Miami-Dade County employees access to a broad network of providers across South Florida through our Premier Access Network and access to the Beech Street nationwide network as well. Members are encouraged, but not required, to select a primary care physician. Benefits covered at 100% after applicable co-payments. Other benefits include health and wellness discount programs, access to a 24-hour on-call nurse, and three months of prescriptions for the price of two – right at your local participating pharmacy. The JMH Health Plan is a not for profit, full service health maintenance organization.
DEDUCTIBLES/ COPAYMENTS	Co-payments \$10 Physician office visit /services 100% Hospital admission coverage - no co-payment \$25/\$50 co-payment Emergency Room (waived if admitted) \$25/\$50 co-payment Urgent Care \$10/ \$20/ \$30 prescription for 30-day supply based on formulary \$20/\$40/\$60 Mail order prescription available for 90-day supply based on formulary	Co-payments \$10 Physician office visit \$0 Hospital admission co-pay \$50 co-payment Emergency Room (waived if admitted) \$25 co-payment Urgent Care \$7/\$20/\$35 Prescriptions for 30 day supply - Open Formulary Mail Order: \$14/\$40/\$70 for 90 day supply
PHYSICIANS	Access any primary care physician or specialist from the Elite Access Network. Members are encouraged but not required to select a primary care physician. Covered family members may choose their own primary care physician.	Choose any physician, primary care or specialist, from the Premier Access Network. Members are encouraged, but not required, to select a primary care physician. Covered family members may choose their own primary care physician. Physician services are covered in full after \$10 co-pay
A. IN-HOSPITAL PHYSICIAN SERVICES: Surgery/Visits & Consultations Anesthesiologist B. OUT-PATIENT PHYSICIAN SERVICES: Office visits for illness Office visits for injury Diagnostic X-Rays, Lab Tests, X-Ray treatments Pediatrician 1) Medically Necessary 2) Preventive (Child Health Supervision Services) Routine Physical Obstetrical/Gynecological	Benefits payable at 100% when received at participating hospitals and rendered by participating physicians. \$10 co-payment; then 100% \$10 co-payment; then 100% 100% \$10 co-payment; 100% thereafter. \$10 co-payment; then 100% \$10 co-payment; 100% thereafter for annual exam. \$10 co-pay, then 100%. Mammograms, PAP smears payable at 100%. Maternity Care: \$10 co-pay for 1st visit, 100% thereafter.	100% \$10 co-payment per visit, 100% thereafter \$10 co-payment per visit, 100% thereafter 100% 1) \$10 co-payment per visit, 100% thereafter. 2) \$10 co-payment per visit, 100% thereafter. \$10 co-payment per visit, 100% thereafter. \$10 co-pay, then 100%. Mammograms, PAP smears payable at 100%. Maternity Care: \$10 co-pay for 1st visit, 100% thereafter.

AVMED & JMH HIGH OPTION (HMO) Plans

	AVMED HEALTH PLANS HIGH OPTION (HMO) Visit our website at www.avmed.org/go/mdpht .	JMH HEALTH PLAN HIGH OPTION (HMO) Visit our website at www.jmhhp.com
Hospitalization:	<p>Benefits payable at 100% at following affiliated hospitals when admitted with PCP authorization:</p> <p>MIAMI-DADE COUNTY</p> <p>Anne Bates Leach Eye Hospital • Aventura • Baptist • Coral Gables • Doctor's Hospital • Hialeah Hospital • Homestead Hospital • Jackson Memorial Hospital • Jackson South Community Hospital • Jackson North Medical Center • Kendall Regional Medical Center • Larkin Community Hospital • Mercy Hospital • Miami Children's • Mt. Sinai Medical Center • North Shore Medical Center • Palmetto General • Select Specialty Hospital • South Miami Hospital • University of Miami Hospital & Clinics</p> <p>BROWARD COUNTY</p> <p>Anne Bates Leach Eye Hospital • Broward General Medical Center • Cleveland Clinic Hospital • Coral Springs Medical Center • Holy Cross Hospital • Imperial Point • Joe Di Maggio Children's Hospital • Memorial Regional Hospital • Memorial Miramar • Memorial Pembroke • Memorial Hospital South • Memorial West • North Broward Medical Center • North Shore Medical-FMC • Northwest Medical Center • Plantation General • University Hospital • Westside Regional Medical Center</p>	<p>Benefits payable at 100% at following affiliated hospitals:</p> <p>MIAMI-DADE COUNTY</p> <p>Anne Bates Leach • Aventura • Baptist • Cedars • Coral Gables Hospital • Doctors Hospital • Hialeah Hospital • Jackson Memorial Hospital • Homestead Hospital • Holtz Children's Hospital • Jackson North Community Hospital • Jackson South Community Hospital • Kendall Regional • Kindred Hospital Coral Gables • Mercy Hospital • Miami Children's • Mt Sinai Medical Center • North Shore • Palmetto General • Palm Springs Hospital • South Miami Hospital • University of Miami/ Hospital & Clinic • West Gables Rehabilitation Hospital</p> <p>BROWARD COUNTY</p> <p>Broward General Medical Center • Coral Springs Hospital • Holy Cross Hospital • Imperial Point • Joe DiMaggio Children's Medical Center • Kindred Hospital Ft Lauderdale • Memorial Hospital Miramar • Memorial Hospital Pembroke • Memorial Hospital South • Memorial Hospital West • Memorial Regional • North Broward Medical Center • North Shore Medical Center-FMC • Northwest Medical Center • Plantation General • University Hospital • Westside Regional Medical Center</p>
Hospital/Surgical Requirements: Precertification of hospital confinements	Handled by admitting physician.	All non-emergency inpatient confinements and physician charges are precertified through the JMH Health Plan.
Drug & Alcohol Treatment: Inpatient	No charge	Covered at 100% up to 30 days inpatient per year.
Outpatient	\$10 per visit	\$10 co-payment per visit, limited to 60 outpatient visits per calendar year.
Mental & Nervous Disorders: Inpatient	No charge	Covered at 100% up to 30 days inpatient per year.
Outpatient	\$10 per visit	\$10 co-payment per visit, limited to 30 outpatient visits per calendar year.
Ambulance	100% when medically necessary	100% when medically necessary
Vision	Coverage provided for diseases of the eye and/or injuries to the eye. Eye exams for children under age 18 covered 100%, after \$10 co-payment. AvMed offers adult vision discounts through a preferred network of providers listed in the Provider Directory. Eye exams, glasses, contact lenses not covered.	100% for eye exam per 12 months.** \$10 dispensing fee, 100% thereafter for select lenses and frames, for one pair of glasses per member per calendar year. Contact lenses not covered, 20% courtesy discount is available for professional fees and materials.

AVMED & JMH HIGH OPTION (HMO) Plans

	AVMED HEALTH PLANS HIGH OPTION (HMO) Visit our website at www.avmed.org/go/mdpht .	JMH HEALTH PLAN HIGH OPTION (HMO) Visit our website at www.jmhhp.com
Prescription Drugs:	\$10 Generic/\$20 Brand/\$30 Non-Preferred for 30 day supply, including prescription contraceptives, at participating pharmacies nationwide. If member/physician select Brand when Generic is available, member pays difference in cost plus Brand co-payment. See plan literature for other participating pharmacies. Mail order: 2x co-pay for 90-day supply.	\$7 Generic/\$20 Brand/\$35 Non-Formulary or refill up to 30-day supply including contraceptives, at CVS, Walgreens, Publix, Navarro, Sedanos, Albertson's, Wal-Mart, Winn Dixie, Costco, Medicine Shoppe, Sams, Kmart, and Target. See plan literature for other participating pharmacies. If member selects Brand when Generic is available, member pays difference in cost plus Brand co-payment. Co-pays required for each prescription per month. Retail or Mail order available 2 x co-payment for 90-day supply (Not all pharmacies participate).
Durable Medical Equipment (DME):	\$50 co-payment per episode of illness. Limited to a maximum of \$2000 per calendar year. Please refer to brochure for limitations and restrictions.	100% of pre-authorized durable medical equipment, orthotic braces and prosthetics devices, obtained through a JMH Health Plan provider. \$25 co-payment per medical condition. Maximum benefit \$2,000 per year. ****
Autism Spectrum Disorder (Includes: Autistic Disorder, Asperger's Syndrome & Pervasive Development Disorder):	Physical, speech, occupational therapy \$10 per visit Applied Behavior Analysis \$10 per visit Coverage for the diagnosis and treatment of Autism Spectrum Disorder includes Physical Therapy, Speech Therapy, Occupational Therapy and Applied Behavior Analysis. Coverage is limited to \$36,000 annually and may not exceed \$200,000 in total lifetime benefits. *	Coverage includes a minimum of three (3) visits per calendar year for the evaluation and/or treatment related to Autism Spectrum Disorder. Coverage provided for Physical, Occupational, Speech and Behavioral Therapies (including Applied Behavior Analysis). Open Access for Specialists: visits/no PCP referral required. Some services may still require prior authorization. Maximum calendar year coverage not to exceed \$36,000. Maximum Lifetime coverage not to exceed \$200,000."
Out of Area: 1) Emergency 2) Non-Emergency	1) \$25 participating, \$50 non-participating co-payment, waived if admitted, 100% thereafter. 2) Not covered if provider is out of network.	1) 100% after \$50 co-payment, waived if admitted (worldwide). 2) Covered within the JMH Health Plan's Premier Access Network.
	*This comparison is not a contract. For specific information on benefits, exclusions and limitations, please see the Summary Plan Description.	** See plan literature for details regarding vision benefits limitations and exclusions. *** See plan literature regarding purchase of non-Generic drugs. **** See plan literature for benefits and limitations of DME products.

AVMED & JMH LOW OPTION (HMO) Plans

COVERAGE PLAN DESCRIPTION	AVMED HEALTH PLANS LOW OPTION (HMO) Visit our website at www.avmed.org/go/mdpht .	JMH HEALTH PLAN LOW OPTION (HMO) Visit our website at www.jmhnp.com
	AvMed offers Miami-Dade County employees, covered dependents and retirees under age 65 access to an expanded network of providers in the state of Florida. In addition, AvMed offers a nationwide network for those residing outside of the service area. The plan provides 100% benefits for covered charges, after applicable co-payments. Members are required to select a primary care physician. AvMed offers 24 hour Member Service, 24 hour Nurse on Call hot lines, discounted health and wellness programs, "Healthy Living" and care management programs personalized to improve the member's health, discounted Mail Order Prescriptions and more.	A managed care program which offers Miami-Dade County employees access to a broad network of providers across South Florida through our Premier Access Network and access to the Beech Street nationwide network as well. Members are required to select a primary care physician. Benefits covered at 100% after applicable co-payments. Other benefits include health and wellness discount programs, access to a 24-hour on-call nurse, and three months of prescriptions for the price of two – right at your local participating pharmacy. The JMH Health Plan is a not for profit, full service health maintenance organization.
DEDUCTIBLES/ COPAYMENTS	Co-payments \$25 Physician office visit /services \$150/day Hospital Admission copay; max \$450 per adm \$100 co-payment Emergency Room (waived if admitted); \$50 co-payment Urgent Care \$15/\$30/\$50 prescription for 30-day supply based on formulary \$30/\$60/\$100 Mail order prescriptions available for 90-day supply based on formulary	Co-payments \$25 Physician office visit \$150/day Hospital admission co-pay; max \$450 per/adm. \$100 co-payment Emergency Room (waived if admitted) \$50 co-payment Urgent Care \$15/\$30/\$50 Prescriptions for 30 day supply - Open Formulary Mail Order: \$30/\$60/\$100 for 90 day supply
PHYSICIANS	Choose any primary care physician from the Elite Access Network. Change primary care physician at any time. Covered family members may choose their own primary care physician.	Choose any primary care physician from the Premier Access Network. Members are required to select a primary care physician. Covered members may select their own primary care physician. Change a primary care physician at any time. Physician services are covered in full after \$25 co-pay
A. IN-HOSPITAL PHYSICIAN SERVICES: Surgery/Visits & Consultations Anesthesiologist B. OUT-PATIENT PHYSICIAN SERVICES: Office visits for illness Office visits for injury Diagnostic X-Rays, Lab Tests, X-Ray treatments Pediatrician 1) Medically Necessary 2) Preventive (Child Health Supervision Services) Routine Physical Obstetrical/Gynecological	100% \$25 co-payment; then 100% thereafter \$25 co-payment; then 100% thereafter 100% 1) \$25 co-payment; then 100% thereafter 2) \$25 co-payment; then 100% thereafter \$25 co-payment; 100% thereafter for annual exam. \$25 co-payment per visit, 100% thereafter. Maternity - \$25 co-payment for 1st visit only.	100% \$25 co-payment per visit, 100% thereafter \$25 co-payment per visit, 100% thereafter 100% 1) \$25 co-payment, then 100% thereafter 2) \$25 co-payment, then 100% thereafter \$25 co-payment per visit, 100% thereafter \$25 co-pay per visit, 100% thereafter. Maternity Care: \$25 co-pay for 1st visit, 100% thereafter.

AVMED & JMH LOW OPTION (HMO) Plans

	AVMED HEALTH PLANS LOW OPTION (HMO) Visit our website at www.avmed.org/go/mdpht .	JMH HEALTH PLAN LOW OPTION (HMO) Visit our website at www.jmhhp.com
Hospitalization:	<p>\$150/day hospital admission /\$450 max per admission at following affiliated hospitals:</p> <p>MIAMI-DADE COUNTY</p> <p>Anne Bates Leach Eye Hospital • Aventura • Baptist • Coral Gables • Doctor's Hospital • Hialeah Hospital • Homestead Hospital • Jackson Memorial Hospital • Jackson South Community Hospital • Jackson North Medical Center • Kendall Regional Medical Center • Larkin Community Hospital • Mercy Hospital • Miami Children's • Mt. Sinai Medical Center • North Shore Medical Center • Palmetto General • Select Specialty Hospital • South Miami Hospital • University of Miami Hospital & Clinics</p> <p>BROWARD COUNTY</p> <p>Anne Bates Leach Eye Hospital • Broward General Medical Center • Cleveland Clinic Hospital • Coral Springs Medical Center • Holy Cross Hospital • Imperial Point • Joe Di Maggio Children's Hospital • Memorial Regional Hospital • Memorial Miramar • Memorial Pembroke • Memorial Hospital South • Memorial West • North Broward Medical Center • North Shore Medical-FMC • Northwest Medical Center • Plantation General • University Hospital • Westside Regional Medical Center</p>	<p>\$150/day limit \$450 per/adm at following affiliated hospitals: Maternity Care: \$25 co-pay for 1st visit, 100% thereafter.</p> <p>MIAMI-DADE COUNTY</p> <p>Anne Bates Leach • Aventura • Baptist • Cedars • Coral Gables Hospital • Doctors Hospital • Hialeah Hospital • Jackson Memorial Hospital • Homestead Hospital • Holtz Children's Hospital • Jackson North Community Hospital • Jackson South Community Hospital • Kendall Regional • Kindred Hospital Coral Gables • Mercy Hospital • Miami Children's • Mt Sinai Medical Center • North Shore • Palmetto General • Palm Springs Hospital • South Miami Hospital • University of Miami/Hospital & Clinic • West Gables Rehabilitation Hospital</p> <p>BROWARD COUNTY</p> <p>Broward General Medical Center • Coral Springs Hospital • Holy Cross Hospital • Imperial Point • Joe DiMaggio Children's Medical Center • Kindred Hospital Ft Lauderdale • Memorial Hospital Miramar • Memorial Hospital Pembroke • Memorial Hospital South • Memorial Hospital West • Memorial Regional • North Broward Medical Center • North Shore Medical Center-FMC • Northwest Medical Center • Plantation General • University Hospital • Westside Regional Medical Center</p>
Hospital/Surgical Requirements: Precertification of hospital confinements	Handled by admitting physician.	All non-emergency inpatient confinements and physician charges are precertified through the JMH Health Plan.
Drug & Alcohol Treatment: Inpatient	\$150/day, for the first 3 days, per admission; no charge thereafter.*	\$150 per admission co-pay; max \$450 per admission up to 30 days inpatient per year.
Outpatient	\$25 per visit	\$10 co-payment per visit, limited to 60 outpatient visits per calendar year.
Mental & Nervous Disorders: Inpatient	\$150/day, for the first 3 days, per admission; no charge thereafter.*	\$150 per admission co-pay; max \$450 per admission up to 30 days inpatient per year.
Outpatient	\$25 per visit	\$10 co-payment per visit, limited to 30 outpatient visits per calendar year.
Ambulance	100% when medically necessary.	100% when medically necessary
Vision	Coverage provided for diseases of the eye and/or injuries to the eye. Eye exams for children under age 18 covered 100%, after \$25 co-payment. AvMed offers adult vision discounts through a preferred network of providers listed in the Provider Directory. Eye exams, glasses, contact lenses not covered.	100% for eye exam per 12 months. ** \$10 dispensing fee, 100% thereafter for select lenses and frames, for one pair of glasses per member per calendar year. Contact lenses not covered, 20% courtesy discount is available for professional fees and materials.

AVMED & JMH LOW OPTION (HMO) Plans

	AVMED HEALTH PLANS LOW OPTION (HMO) Visit our website at www.avmed.org/go/ldpht .	JMH HEALTH PLAN LOW OPTION (HMO) Visit our website at www.jmhhp.com
Prescription Drugs:	\$15 Generic/\$30 Brand/\$50 Non-Formulary or refill up to 30-day supply including contraceptives, at CVS, Walgreens, Publix, Navarro, Sedanos, Albertson's, Wal-Mart, Winn Dixie, Costco, Medicine Shoppe, Sams, Kmart, and Target. See plan literature for other participating pharmacies. If member selects Brand when Generic is available, member pays difference in cost plus Brand co-payment. Co-pays required for each prescription per month. Retail or Mail order available 2 x co-payment for 90-day supply (Not all pharmacies participate).	\$15 Generic/\$30 Brand/\$50 Non-Formulary or refill up to 30-day supply including contraceptives, at CVS, Walgreens, Publix, Navarro, Sedanos, Albertson's, Wal-Mart, Winn Dixie, Costco, Medicine Shoppe, Sams, Kmart, and Target. See plan literature for other participating pharmacies. If member selects Brand when Generic is available, member pays difference in cost plus Brand co-payment. Co-pays required for each prescription per month. Retail or Mail order available 2 x co-payment for 90-day supply (Not all pharmacies participate).
Durable Medical Equipment (DME):	\$50 co-payment per episode of illness. Limited to a maximum of \$500 per calendar year. Please refer to brochure for limitations and restrictions.	100% of pre-authorized durable medical equipment, orthotic braces and prosthetics devices, obtained through a JMH Health Plan provider. \$50 co-payment per medical condition. Maximum benefit \$2,000 per year. ****
Autism Spectrum Disorder (Includes: Autistic Disorder, Asperger's Syndrome & Pervasive Development Disorder):	Physical, Speech, Occupational Therapy \$25 per visit Applied Behavior Analysis \$25 per visit Coverage for the diagnosis and treatment of Autism Spectrum Disorder includes Physical Therapy, Speech Therapy, Occupational Therapy and Applied Behavior Analysis. Coverage is limited to \$36,000 annually and may not exceed \$200,000 in total lifetime benefits. *	Coverage includes a minimum of three (3) visits per calendar year for the evaluation and/or treatment related to Autism Spectrum Disorder. Coverage provided for Physical, Occupational, Speech and Behavioral Therapies (including Applied Behavior Analysis). Open Access for Specialists - visits/no PCP referral required. Some services may still require prior authorization. Maximum calendar year coverage not to exceed \$36,000. Maximum Lifetime coverage not to exceed \$200,000."
Out of Area: 1) Emergency 2) Non-Emergency	1) \$100 co-pay, waived if admitted, 100% thereafter. \$50 urgent care center co-pay. 2) Not covered if provider is out of network.	100% after \$100 co-payment, waived if admitted (worldwide). 2) Covered within the JMH Health Plan's Premier Access Network.
	*This comparison is not a contract. For specific information on benefits, exclusions and limitations, please see the Summary Plan Description.	** See plan literature for details regarding vision benefits limitations and exclusions. *** See plan literature regarding purchase of non-Generic drugs. **** See plan literature for benefits and limitations of DME products.

DELTA Dental Plan

	DELTA	
Choice of Dentist	Choose any dentist you wish for services and receive applicable benefits. Save the most with a Delta Dental PPO network participating dentist. Percentages below are based on Delta's applicable allowances and not the dentist's actual charge. Payments to non preferred providers are based on Reasonable and Customary (not billed) charges.	
Maximum Benefit/Deductible	\$1,000 per year per person \$50 deductible per year per person; \$150 family maximum	\$1,500 per year per person \$50 deductible per year per person; \$150 family maximum
Type I 0150 Comprehensive Oral Evaluation -New or Established 0120 Periodic Oral Exam X-rays 1110/20 Prophylaxis 1203 Fluoride Treatment (children up to the age 19) 1351 Sealant - per tooth 1510 Space Maintainers	STANDARD Plan Pays (No deductible) 100% 100% 100% 100% (Twice per calendar year) 100%, 2x per year 100% to age 16 100% to age 19	ENRICHED Plan Pays (No deductible) 100% 100% 100% 100% (Twice per calendar year) 100%, 2x per year 100% to age 16 100% to age 19
Type II Fillings: (silver) 2330 one surface 2331 two surfaces 2332 three surfaces 2335 four or more surfaces Root canals: 3310 Anterior 3320 Bicuspid 3330 Molar 3410 Apicoectomy Extractions: 7111 Single tooth 7140 Extraction, erupted tooth or exposed tooth 7210 Surgical extraction of erupted tooth Periodontics: (gum treatment) 4341 Periodontal scaling & root planning-per quadrant 4210 Gingivectomy/gingivoplasty - per quadrant 4910 Periodontal maintenance procedures	 * 100% PDP/ 75% NON PDP 100% PDP/ 75% NON PDP 100% PDP/ 75% NON PDP 100% PDP/ 75% NON PDP 75% 75% 75% 75% 75% 75% 75% 75% 75% 75%	 * 100% PDP/ 75% NON PDP 100% PDP/ 75% NON PDP 100% PDP/ 75% NON PDP 100% PDP/ 75% NON PDP 75% 75% 75% 75% 75% 75% 75%
Type III Crown & Bridge 2930 Prefabricated stainless steel primary tooth 2791 Crown full cast predominately base metal 2751 Crown Porcelain fused to base metal Pontics: 6210 Full cast 6240 Porcelain fused to metal Prostodontics (Dentures) 5110 Complete upper 5120 Complete lower 5213/14 Partial upper or lower - cast metal base	 * 50% 50% 50% 50% 50% 50% 50% 50%	 * 50% 50% 50% 50% 50% 50% 50% 50%
ORTHODONTIA Consultation Evaluation Records Children - Normal Class II Adult - Normal Class II 8750 Retention	Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered	Adult & Children covered at 50% after a one time deductible of \$50 per person. \$1,000 lifetime maximum
VISION Examination Single Vision Lenses Bifocal Lenses Trifocal Lenses Contact Lenses - Non-Elective Contact Lenses - Elective Frames	Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered

* All Type II and III charges subject to annual deductible

* The above reimbursements are exclusive of gold.

ADP & OHS Dental Plans

AMERICAN DENTAL PLAN (ADP) Now known as CompBenefits		ORAL HEALTH SERVICES (OHS) Now known as CompBenefits	
Limited to Participating Dentists in Private Practice		Limited to Participating Dentists in Private Practice	
No Maximum No Deductible		No Maximum No Deductible	
STANDARD You Pay* No Charge No Charge No Charge No Charge (Once every 6 months) No Charge 7.00 35.00	ENRICHED You Pay No Charge No Charge No Charge No Charge (Once every 6 months) No Charge 7.00 35.00	STANDARD You Pay No Charge No Charge No Charge No Charge (Once every 6 months) No Charge 6.00 40.00	ENRICHED You Pay No Charge No Charge No Charge No Charge (Once every 6 months) No Charge No Charge No Charge
No Charge No Charge No Charge No Charge 95.00 135.00 175.00 65.00 No Charge No Charge 20.00 37.50 105.00 UCR Less 25%	No Charge No Charge No Charge No Charge 95.00 135.00 175.00 65.00 No Charge No Charge 20.00 37.50 105.00 35.00	No Charge \$11.00 \$16.00 \$18.00 90.00 155.00 200.00 75.00 No Charge No Charge 15.00 40.00 120.00 25.00	No Charge No Charge No Charge No Charge 45.00 90.00 145.00 65.00 No Charge No Charge No Charge 40.00 90.00 25% Discount
35.00 185.00** 200.00** 185.00** 200.00** 200.00 200.00 250.00	35.00 185.00** 200.00** 185.00** 200.00** 200.00 200.00 250.00	25.00 \$210.00 \$210.00 25% Discount 25% Discount 230.00 230.00 275.00	No Charge \$175.00 \$175.00 25% Discount 25% Discount 205.00 205.00 240.00
No Charge UCR Less 25% UCR Less 25% UCR Less 25% UCR Less 25% Additional	No Charge 35.00 250.00 1400.00 1950.00 Additional	25% Discount 25% Discount 25% Discount 25% Discount 25% Discount 25% Discount	No Charge 25.00 200.00 1,400.00 1,950.00 25% Discount
Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered	Not Covered Up to 50% off doctor's prices Up to 50% off doctor's prices Up to 50% off doctor's prices Up to 50% off doctor's prices Up to 50% off doctor's prices Up to 50% off doctor's prices	Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered	10% Discount 20% Discount 20% Discount 20% Discount 20% Discount 20% Discount 20% Discount

* STD Plan fee apply to participating General Dentist only.

** Co-payments are exclusive of gold.

* Cost of high noble metal additional.

Disability Income Protection Plans

Disability insurance protects one of your most valuable assets: the ability to work. Chances are that you do not have enough money in your personal or other long-term savings accounts that would allow you to miss more than two months of work without suffering financial consequences.

The following Disability Income Protection Insurance plans can provide you with a weekly (STD) benefit or monthly (LTD) benefit if you become disabled, as defined in the policy. Choose short term or long term disability income protection insurance, or both. An employee must be actively at work for coverage to begin. Minimum requirement for active employment is 60 hours bi-weekly.

Evidence of Insurability (EOI) will be required during the open enrollment for employees who previously chose not to enroll or if you wish to increase the level of coverage. Employees are required to complete a MetLife disability statement of health which is subject to medical approval. Short-Term and Long-Term Disability insurance that requires medical evidence of insurability will not become effective until your EOI application is approved by MetLife and you are actively at work. Employees may download a MetLife evidence of insurability/statement of health form from the online menu. The completed statement of health must be submitted directly to MetLife at the address provided on page 2 of this book. You may reduce the level of coverage (change from the High Option to the Low Option Plan) during this enrollment period without any evidence of insurability.

Short-Term Disability (STD) Income Protection Highlights

- The Short-Term Disability (STD) Insurance plan may provide up to 60% of your weekly salary, with a maximum benefit of \$500 (STD Low Option Plan) or \$1,000 (STD High Option Plan) per week.
- Short term disability benefit payments are issued in arrears on a weekly basis, and benefits can continue for each period of disability, but not beyond the maximum benefit period of 26 weeks.
- STD benefits start to accrue after you meet the definition of disability and satisfy a 14-consecutive-day waiting period, or the expiration of all sick leave, whichever is later. Annual leave will automatically be used unless you submit a written request for it not to be paid to you.
- Pregnancy/childbirth is considered a disability just like any other illness or injury that may occur while covered under this plan. For a normal childbirth, disability typically covers you up to a total of six weeks. (Example, if you have two weeks of sick leave, your MetLife benefits would be payable for four weeks.)
- To receive benefits, you must be unable to earn more than 80% of pre disability earnings at your own occupation as a result of sickness or injury.
- No pre-existing limitation clause applies.
- There is no waiver of premium if approved for benefits.

What's Not Covered

Sickness or injuries not covered are those resulting from:

- War, declared or undeclared, or acts of war, insurrection, rebellion, or terrorist act.
- Active participation in a riot.
- Committing or attempting to commit a felony or assault.
- Intentionally self-inflicted injuries.
- Attempted Suicide.
- Work related injury or sickness.

Long-Term Disability (LTD) Income Protection Highlights

- The Long-Term Disability (LTD) Insurance plan can provide up to 60% of your monthly salary, with a maximum benefit of \$2,000 LTD Low Option Plan or \$4,000 (LTD High Option Plan) per month.
- Benefits can continue for each period of total disability according to the schedule below.
- The minimum monthly benefit is the greater of \$100, or 10 percent of the gross monthly benefit before deductions for other income benefits.
- Pre-existing limitation clause applies.

LTD benefits start to accrue after you meet the definition of disability as defined in the policy and satisfy the waiting period of 180 days. Before LTD benefits will begin, an employee must exhaust any short-term disability or the expiration of all sick leave, whichever occurs later. Annual leave will automatically be used unless you submit a written request for it not to be paid to you.

- As long as you are receiving disability benefits from MetLife, your monthly premiums are waived.

Age at time of Disability:	LTD Benefits payable for following
maximum: Under 60	To age 65, but no less than 60 months
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and Over	12 months

Long-Term Definition of Disability:

You are disabled when MetLife determines that:

1. Due to Sickness, or as a direct result of accidental injury, you are receiving appropriate care and treatment and complying with the requirements of such treatment; and
2. You are unable to earn more than 80% of your pre-disability earnings at your own occupation for any employer in your local economy.

Disability Income Protection Plans

Long-Term Disability Income Protection (cont.)

After 24 months of payments, you are disabled when MetLife determines that:

1. Due to Sickness, or as a direct result of accidental injury, you are receiving appropriate care and treatment and complying with the requirements of such treatment; and
2. You are unable to earn more than 80% of your pre-disability earnings from any employer in your local economy at any gainful occupation for which they are reasonably qualified taking into account their training, prior education and experience.

Rehabilitation and Return to Work Assistance:

Vocational rehabilitation experts provide qualified employees with formalized assessment and planning as well as financial support to help them return to productive, independent lifestyles.

What's Not Covered

Sickness or injuries not covered are those resulting from:

- War, declared or undeclared, or acts of war, insurrection, rebellion, or terrorist act.
- Active participation in a riot
- Committing or attempting to commit a felony or assault.
- Intentionally self-inflicted injuries.
- Attempted Suicide.

Annual Leave and Your Disability Benefits

If you are on sick leave and your sick leave runs out, the County automatically uses any accrued annual leave. However, if you purchase short-term or long-term disability insurance, you can choose not to be paid for your annual leave even if you exhaust your sick leave. Contact your Departmental Personnel Representative and request in writing that your annual leave not be paid to you during your absence from work due to illness or injury.

What if I receive benefits from another group disability plan, Social Security or the Florida Retirement System?

Both the short-term and long-term disability plans coordinate with benefits payable under any statutory disability law, the Federal Social Security Act and any other federal, state, county or municipal retirement acts or laws. These benefits also coordinate with any other group policies you may have that provide disability benefits. Any employer-sponsored salary continuation or retirement program benefits are coordinated as well.

Coordination of disability benefits means the disability payments you receive are offset by the amount you receive from other sources of income as defined in the policy.

Termination of Coverage

Your coverage under the policy ends on the earliest of the following:

- the date the group policy or plan is cancelled. Employees may cancel coverage within 45 days of going in a no pay status or obtaining disability coverage through another group plan.
 - the date you no longer are in an eligible group.
 - the date your eligible group is no longer covered.
 - the last day of the period for which you made any required contributions.
- or

- the last day you are in active employment except as provided under the covered layoff or leave of absence provision.

MetLife will provide coverage for a payable claim which occurs while you are covered under the policy or plan.

Delayed Effective Date

This insurance coverage will be delayed if you are not in active employment because of injury, sickness, temporary layoff or leave of absence on the date that this insurance would otherwise become effective.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations that may affect any benefits payable. For complete details of coverage and availability, please refer to the Policy.

Policy Provider

Metropolitan Life Insurance Company underwrites these plans.

MetLife Disability (888) 463-2023 - www.metlife.com/mybenefits:

File a disability claim online, check the status and details of your claim.

Biweekly premiums

Short Term (Low Option and High Option plans):

\$1.54 per \$100 of Weekly Benefit

Long Term (Low Option plan): \$0.26 per \$100 of Covered Payroll

Long Term (High Option plan): \$0.31 per \$100 of Covered Payroll

Disability Calculator

STD Low Option:

Biweekly Premium = Adj. Biweekly Salary
(capped at \$1,666.67) $\div 2 \times 0.60 \times 0.0154$

STD High Option:

Biweekly Premium = Adj. Biweekly Salary
(capped at \$3,333.34) $\div 2 \times 0.60 \times 0.0154$

LTD Low Option:

Biweekly Premium = Adj. Biweekly Salary
(capped at \$1,538.76) $\times 26 \div 12 \times 0.0026$

LTD High Option:

Biweekly Premium = Adj. Biweekly Salary
(capped at \$3,077.52) $\times 26 \div 12 \times 0.0031$

Disability Online Calculator

**<http://www.miamidade.gov/benefits> and
check on left navigation link for Calculator.**

FBMC - Flexible Spending Accounts

FBMC's Web site provides information regarding your benefits and comprehensive details on your Flexible Spending Account(s). By entering www.myFBMC.com into your Internet browser, you will open FBMC's homepage. Answers to many of your Flexible Spending Accounts questions can be obtained by using the following navigational tabs located along the top portion of the home page.

Account Information

If you previously registered an e-mail address and password on FBMC's Web site, you may continue using this information. If you haven't registered, or if you registered prior to January 19, 2008, log in to the site as a first time user. Follow the link on the login page and register through the FBMC Premier Login. After this login, the following menu items will be available to you.

- **Benefits**- includes information on current benefits, such as effective date, number of deductions and pre-tax annual contribution
- **Claims**- provides information on open and current reimbursement claims such as date received, status and amount authorized
- **Accounts** - allows review of transactions from your current and previous plan years, including run-out period information, payment status and account availability
- **Profile** - helps you keep your personal information current, as well as manage your password and e-mail address
- **Resources** - gives you access to downloadable forms, such as FSA Reimbursement Requests and Direct Deposit forms, and FAQs

Downloading Forms

When you select the 'Download Forms' tab, a choice of forms, including a Letter of Medical Need, FSA Reimbursement Request Form and Direct Deposit Form, are posted for your convenience.

Frequently Asked Questions

The 'Frequently Asked Questions' tab provides answers to many of your general questions regarding Flexible Spending Accounts and enrollment information.

FBMC Customer Care Center

Clicking on the "Contact" tab gives you a direct link to the FBMC Customer Service Center.

FBMC Interactive Benefits

FBMC's 24-hour automated phone system, Interactive Voice Response (IVR), can be reached by calling 1-800-865-FBMC (3262). This system allows you to access your benefits any time. By following the voice prompts, you can find out a great deal of information about your benefits.

- Current Account Balance(s)
- Claim Status
- Mailing Address Verification
- Obtain FSA Reimbursement Request Claim Forms
- Change Your PIN

Personal Identification Number (PIN)

To access Interactive Voice Response (IVR) system, all you need is your Social Security number (SSN). The last four digits of your SSN will be your first PIN. After your initial login, you will be asked to

register and select your own confidential PIN to access this system in the future. Your new PIN cannot be the last four digits of your SSN, cannot be longer than eight digits and must be greater than zero. If you forget your PIN, call FBMC Customer Service at 1-800-342-8017

Note: Please be sure to keep this Reference Guide in a safe, convenient place, and refer to it for benefit information.

Enrollment

If you wish to continue your Flexible Spending Accounts you must enroll, re-enroll online each year.

What are the Flexible Benefits Plan Administrative Fees per pay period?

Healthcare Spending Account only.....	\$1.96
Dependent Care Spending Account only.....	\$1.96
Both Healthcare and Dependent Spending Accounts.....	\$1.96

What is my FSA Period of Coverage?

Your period of coverage for FSAs is your full plan year, unless you make a permitted mid-plan year election change, terminate employment or lose eligibility for group coverage. A mid-plan year election change will result in split periods of coverage, creating more than one period of coverage within a plan year with expenses reimbursed from the appropriate period of coverage. Money from a previous period of coverage can be combined with amounts after a permitted mid-plan year election change. However, expenses incurred before the permitted election change can only be reimbursed from the amount of the balance present in the FSA prior to the change. Mid-plan year election changes are approved only if the extenuating circumstances and supporting documentation are within your employer's, insurance provider's and IRS regulations governing the plan.

Flexible Spending Accounts

What is a Flexible Spending Account (FSA)?

Fringe Benefits Management Company (FBMC) provides you with IRS tax-favored FSAs to stretch your medical expense and dependent care dollars.

Flexible Spending Accounts feature:

- IRS-approved reimbursement of eligible expenses tax free
- per-pay-period deposits from your pre-tax salary and
- savings on income and Social Security taxes.

Is an FSA right for me?

If you spend \$260 or more on recurring eligible expenses during your plan year, you may save money by paying for them with an FSA. A portion of your salary is deposited into your FSA each pay period.

- You decide the amount you want deposited.
- You are reimbursed for eligible expenses before income and Social Security taxes are deducted.
- You save income and Social Security taxes each time you receive wages.
- Determine your potential savings with a Tax Savings Analysis at www.myFBMC.com.

What types of FSAs are available?

Your employer offers you a Healthcare FSA as well as a Dependent Care FSA. If you incur both types of expenses during a plan year, you can establish both types of FSAs.

Healthcare FSAs

Medical expenses not covered by your insurance plan may be eligible for reimbursement using your Healthcare FSA, including:

- birth control pills
- eyeglasses
- orthodontia and
- Over-the-Counter items. (see FBMC's Web site for quarterly updates)

Dependent Care FSAs

Dependent care expenses, whether for a child or an elder, include any expense that allows you to work, such as:

- day care services
- in-home care
- nursery and preschool and
- summer day camps.

Refer to the Healthcare FSA and Dependent Care FSA sections of this Reference Guide for specifics on each type of FSA.

Receiving Reimbursement

Your reimbursement will be processed within five business days from the time FBMC receives your properly completed and signed FSA Reimbursement Request Form. To avoid delays, follow the instructions for submitting your requests located in the FSA materials you will receive following enrollment.

Direct Deposit

Enroll in Direct Deposit to expedite the time of your reimbursement.

- FSA reimbursement funds are automatically deposited into your checking or savings account.
- There is no fee for this service.
- You don't have to wait for postal service delivery of your reimbursement (however, you will receive notification that the claim has been processed).

To apply, complete the Direct Deposit Enrollment Form available from FBMC's website at www.myFBMC.com or call FBMC Customer Service at 1-800-342-8017. Please note that processing your Direct Deposit enrollment may take between four to six weeks.

Where can I get information about FSAs?

If you have specific questions about FSAs, contact FBMC Customer Care Center.

- Visit www.myFBMC.com.
- Call 1-800-342-8017 (Monday-Friday, 7 a.m.-10 p.m. ET).

Please note that due to FBMC's Privacy Policy, we will not discuss your account information with others without your verbal or written authorization.

FSA Savings Example*

\$31,000	Annual Gross Income	\$31,000
- 5,000	FSA Deposit for Recurring Expenses	- 0
<u>\$26,000</u>	Taxable Gross Income	<u>\$31,000</u>
- 5,889	Federal, Social Security Taxes	-7,021
<u>\$20,111</u>	Annual Net Income	<u>\$23,979</u>
- 0	Cost of Recurring Expenses	-5,000
<u>\$20,111</u>	Spendable Income	<u>\$18,979</u>

By using an FSA to pay for anticipated recurring expenses, you convert the money you save in taxes to additional spendable income. That's a potential annual savings of

\$1,132!

*Based upon a 22.65% tax rate (15% federal and 7.65% Social Security) calculated on a calendar year

Flexible Spending Accounts

FSA Guidelines:

1. The IRS does not allow you to pay your medical or other insurance premiums through either type of FSA. Refer to the "Written Certification" portion of the Beyond Your Benefits section of this Benefits Handbook for more specifics.
2. You cannot transfer money between FSAs or pay a dependent care expense from your Healthcare FSA or vice versa.
3. You have a grace period of two months and 15 days following the end of your Plan Year (December 31) for a Healthcare FSA. This grace period ends on March 15. During the grace period, you may incur expenses and submit claims for these expenses. Funds will be automatically deducted from any remaining dollars in your Healthcare FSA balance.
4. You have a 120-day run-out period (until April 30) following the end of the plan year, for reimbursement of eligible FSA expenses incurred during your period of coverage.
5. You may not receive insurance benefits or any other compensation for expenses which are reimbursed through your FSAs.
6. You cannot deduct reimbursed expenses for income tax purposes.
7. You may not be reimbursed for a service that you have not yet received.
8. Be conservative when estimating your medical and/or dependent care expenses for the Plan Year. IRS regulations state that any unused funds which remain in your FSA after a plan year and grace period ends (and all reimbursable requests have been submitted and processed) cannot be returned to you nor carried forward to the next plan year.

Termination or Leave:

If you terminate employment or go on unpaid leave, your eligibility for either or both FSAs may change.

Healthcare FSAs

If you experience an event permitting a mid-plan year FSA election change such as termination of employment or unpaid leave, you can continue to contribute to your Healthcare FSA on an after-tax basis by calling FBMC Customer Care Center at 1-800-342-8017 within **45 days** (60 days for newborns/adoption or placement).

As long as you make full after-tax contributions to your Healthcare FSA, you can receive reimbursements on eligible healthcare expenses incurred during your period of coverage.

You have a 120-day run-out period (until April 30) after the plan year ends to submit claims for reimbursement of eligible FSA expenses which you incurred during your period of coverage. (normally Jan. 1-Dec. 31, however, should you terminate employment prior to Dec. 31, your FSA will cease at the end of the month of termination). Your Healthcare FSA coverage will not be continued beyond the plan year in which the COBRA-qualifying event occurred.

Specific guidelines about termination and leave policies can be obtained from your DPR. In addition, the Family and Medical Leave Act (FMLA) may affect your rights to continue coverage while on leave. Please contact your DPR for further information and to obtain any paperwork necessary to complete.

The Family and Medical Leave Act (FMLA) may affect your rights to continue coverage when on leave. Please contact your DPR for further information.

Dependent Care FSAs

You cannot continue contributing to your Dependent Care FSA. You can, however, continue to request reimbursement for eligible expenses incurred while employed until you exhaust your account balance or the plan year ends.

What documentation of expenses do I need to keep?

The IRS requires FSA customers to maintain complete documentation, including keeping copies of receipts for reimbursed expenses, for a minimum of one year.

How do I get the forms I need?

To obtain forms you will need after enrolling in either a Healthcare or Dependent Care FSA, such as an FSA Reimbursement Request Form, Letter of Medical Need or Direct Deposit Form, you can visit FBMC's Web site, www.myFBMC.com, or call FBMC Customer Service at 1-800-342-8017. For more information, refer to the Getting Answers section of this book.

Will contributions affect my income taxes?

Salary reductions made under a cafeteria plan, including contributions to one or both FSAs, will lower your taxable income and taxes. These reductions are one of the money-saving aspects of starting an FSA. Depending on the state, additional state income tax savings or credits may also be available. Your salary reductions will reduce earned income for purposes of the federal Earned Income Tax Credit (EITC).

To help you choose between the available taxable and tax-free benefits, or a combination of both, consult your tax advisor and/or the IRS for additional information.

Patriot Act

In June 2008, President Bush signed a law that allows military personnel called to duty for a minimum of 180 days to receive taxable distribution of unused medical Flexible Spending Account (FSA) funds. Some of the changes made by the Act are permissive while others mandatory.

The bill defines "qualified reservist distribution" as any distribution to an individual of all or a portion of the balance in the employee's medical FSA account under such arrangement if:

- the individual is a member of a "reserve component" as defined in section 101 of title 37 of the United States Code
- the distribution is made only to a member that has been ordered or called to active duty for 180 days or more or for an indefinite period
- the distribution is made during the period beginning on the date the member is ordered or called and ending on the last date that reimbursements could otherwise be made under such arrangement for the plan year that includes the date of order or call.

Healthcare FSA

Healthcare FSA

Minimum Annual Deposit:

\$260 per year (\$10 per pay period)

Maximum Annual Deposit: \$5,000

(including a \$50.96 annual administrative fee)

What is a Healthcare FSA?

A Healthcare FSA is an IRS tax-favored account you can use to pay for your eligible medical expenses not covered by your insurance or any other plan. These funds are set aside from your salary before taxes are deducted, allowing you to pay your eligible expenses tax free. A partial list of these eligible expenses can be found in this section.

Whose expenses are eligible?

Your Healthcare FSA may be used to reimburse eligible expenses incurred by:

- yourself
- your spouse
- your qualifying child or
- your qualifying relative.

An individual is a qualifying child if they:

- are a U.S. citizen, national or a resident of the U.S., Mexico or Canada
- have a specified family-type relationship to you
- live in your household for more than half of the taxable year
- are 18 years old or younger (23 years, if a full-time student) at the end of the taxable year and
- have not provided more than one-half of their own support during the taxable year (and receive more than one-half of their support from you during the taxable year if a full-time student age 19 through 23 at the end of the taxable year).

An individual is a qualifying relative if they are a U.S. citizen, national or a resident of the U.S., Mexico or Canada and:

- have a specified family-type relationship to you, are not someone else's qualifying child and receive more than one-half of their support from you during the taxable year or
- if no specified family-type relationship to you exists, are a member of and live in your household (without violating local law) for the entire taxable year and receive more than one-half of their support from you during the taxable year.

Note: There is no age requirement for a qualifying child if he/she is physically and/or mentally incapable of self care. An eligible child of divorced parents is treated as a dependent of both, so either or both parents can establish a Healthcare FSA.

When are my funds available?

Once you sign up for a Healthcare FSA and decide how much to contribute, the maximum annual amount of reimbursement for eligible health care expenses will be available throughout your period of coverage.

Since you don't have to wait for the cash to accumulate in your account, you can use it to pay for your eligible health care expenses at the start of the plan year.

Are prescriptions eligible for reimbursement?

Yes, most filled prescriptions are eligible for Healthcare FSA reimbursement, as long as you properly substantiate the expense. Proper submission of the reimbursement request is needed to ensure that the drug is eligible for reimbursement. The IRS requires the complete name of all medicines and drugs be obtained and documented on pharmacy receipts (including prescription name, date(s) of service, and total dollar amount). This information must be included when submitting your request to FBMC for reimbursement.

Can travel expenses for medical care be reimbursed?

Travel expenses primarily for, and essential to, receiving medical care, including health care provider and pharmacy visits, may be reimbursable through your Healthcare FSA. With proper substantiation, eligible expenses can include:

- actual round-trip mileage
- parking fees
- tolls and
- transportation to another city.

Is orthodontic treatment reimbursable?

Orthodontic treatment designed to treat a specific medical condition is reimbursable if the proper documentation is attached to the initial FSA Reimbursement Request Form each plan year:

- a written statement, bill or invoice from the treating dentist/orthodontist showing the type and date the service was incurred, the name of the eligible individual receiving the service and the cost for the service and
- a copy of the patient's contract with the dentist/orthodontist for the orthodontia treatment.

Reimbursement of the full or initial payment amount may only occur during the plan year in which the braces are first installed. For reimbursement options available under your employer's plan, including care that extends beyond one or more plan years, refer to the information provided following your enrollment, or call FBMC Customer Service at 1-800-342-8017.

Should I claim my expenses on IRS Form 1040?

With a Healthcare FSA, the money you set aside for health care expenses is deducted from your salary before taxes. It is always tax free, regardless of the amount. By enrolling in a Healthcare FSA, you guarantee your savings.

Itemizing your health care expenses on your IRS Form 1040 may give you a different tax advantage, depending on their percentage of your adjusted gross income. You should consult a tax professional to determine which avenue is right for you.

Healthcare FSA Directory

Are some expenses ineligible?

Expenses not eligible for reimbursement through your Healthcare FSA include:

- insurance premiums
- vision warranties and service contracts and
- cosmetic surgery not deemed medically necessary to alleviate, mitigate or prevent a medical condition.

Complete information on ineligible expense can be found in IRS Publication 502 at www.irs.gov.

When do I request reimbursement?

You may use your Healthcare FSA to reimburse eligible expenses after you have sought (and exhausted) all means of reimbursement provided by your employer and any other appropriate resource. Also keep in mind that some eligible expenses are reimbursable on the date available, not the date ordered.

How do I request reimbursement?

Requesting reimbursement from your Healthcare FSA is easy. Simply mail or fax a correctly completed FSA Reimbursement Request Form along with the following:

- a receipt, invoice or bill from your health care provider listing the date you received the service, the cost of the service, the specific type of service and the person for whom the service was provided and
- an Explanation of Benefits (EOB)* from your health insurance provider that shows the specific type of service you received, the date and cost of the service and any uninsured portion of the cost or
- a written statement from your health care provider indicating the service was medically necessary if those services could be deemed cosmetic in nature, accompanied by the receipt, invoice or bill for the service.

Mail to: Contract Administrator
Fringe Benefits Management Company
P.O. Box 1800
Tallahassee, FL 32302-1800

Fax to: 866-440-7154

Visit www.myFBMC.com for a list of frequently asked questions.

You must keep your receipts for a minimum of one year and submit to FBMC upon request.

*EOBs are not required if your coverage is through a HMO.

Partial List of Medically Necessary Eligible Expenses*

Acupuncture
Ambulance service
Birth control pills and devices
Chiropractic care
Contact lenses (corrective)
Dental fees
Diagnostic tests/health screening
Doctor fees
Drug addiction/alcoholism treatment
Drugs
Experimental medical treatment
Eyeglasses
Guide dogs
Hearing aids and exams
Injections and vaccinations
In vitro fertilization
Lasik
Nursing services
Optometrist fees
Orthodontic treatment
Over-the-Counter items
Prescription drugs to alleviate nicotine withdrawal symptoms
Smoking cessation programs/treatments
Surgery
Transportation for medical care
Weight-loss programs/meetings
Wheelchairs
X-rays

Note: Budget conservatively. No reimbursement or refund of Healthcare FSA funds is available for services that do not occur within your plan year or grace period.

**IRS-qualified expenses are subject to federal regulatory change at any time during a tax year. Certain other substantiation requirements and restrictions may apply, and will be supplied to you following enrollment.*

OTC Category Reimbursement

Over-the-Counter Expenses

Your Over-the-Counter (OTC) items, medicines and drugs may be reimbursable through your Healthcare FSA! Save valuable tax dollars on certain categories of OTC items, medicines and drugs. You may be reimbursed for OTCs through your Healthcare FSA if:

- the item, medicine or drug was used for a specific medical condition for you, your spouse and/or your dependent(s)
- the submitted receipt clearly states the purchase date and name of the item, medicine or drug
- the reimbursement request is for an expense allowed by your employer's Healthcare FSA plan and IRS regulations and
- you submit your reimbursement request in a timely and complete manner already described in your benefits enrollment information.

Note: OTC items, medicines and drugs, including bulk purchases, must be used in the same plan year in which you claim reimbursement for their cost. The list of eligible OTC categories will be updated on a quarterly basis by FBMC. It is your responsibility to remain informed of updates to this listing, which can be found at www.myFBMC.com. As soon as an OTC item, medicine or drug becomes eligible under any of the categories below, it will be reimbursable retroactively to the start of the current plan year.

Newly eligible OTC items, medicines and drugs are not considered a valid change in status event that would allow you to change your annual Healthcare FSA election or salary reduction amount. Be sure to maintain sufficient documentation to submit receipts for reimbursement. You may resubmit a copy of your receipt from your records if a rejected OTC expense becomes eligible for reimbursement later in the same plan year.

Eligible Expense Categories

Allergy

Antihistamines
Nasal sprays

Antacids

Heartburn medicines

Cold Remedies

Cough drops
Decongestants
Nasal strips
Nasal sprays
Sinus medications
Throat lozenges

Pain Relief

Bug bite medication
Fever reducers
First aid creams (diaper, fever blister, poison ivy)
Menstrual cycle products for pain and cramp relief
Products for muscle or joint pain
Special ointments or creams for sunburn
Topical creams

Other Medical Remedy Items

Anti-diarrheals
Anti-fungals
Antibiotics
Asthma medications
Bandages, gauze pads, rubbing alcohol, liquid adhesives
Carpal tunnel wrist supports
Cold/hot packs for injuries
Corn/callus removers
Eye products (including reading glasses, contact lens cleaning solutions)
First aid kits
Hemorrhoid treatments
Laxatives
Motion sickness treatments
Nicotine gum or patches for smoking cessation purposes
Thermometers
Wart removers

Items Requiring Special Documentation*

Botanicals/herbals
Feminine hygiene products
Hormones
Minerals
Nasal sprays for snoring
Sunscreens
Vitamins
Weight-loss drugs to treat a specific disease

Ineligible OTC Expenses

Cosmetics
Toiletries
OTC items primarily for general health and well-being

* Contact FBMC at www.myFBMC.com or call FBMC Customer Care Center 1-800-342-8017 for more information or to obtain a sample Letter of Medical Need or Personal Use/Capital Expenditures Statement.

Dependent Care FSA

Minimum Annual Deposit:

\$260 per year (\$10 per pay period)

Maximum Annual Deposit: The maximum contribution depends on your tax filing status as the list below indicates.

(including a \$50.96 annual administrative fee)

Partial List of Eligible Expenses*

After school care
Baby-sitting fees
Day care services
In-home care/au pair services
Nursery and preschool
Summer day camps

Note: Budget conservatively. No reimbursement or refund of Dependent Care FSA funds is available for services that do not occur within your plan year.

* IRS-qualified expenses are subject to federal regulatory change at any time during a tax year. Certain other substantiation requirements and restrictions may apply, and will be supplied to you following enrollment.

- spend at least eight hours per day in your home
- receive more than one-half of their support from you during the taxable year.

Note: If you are the tax dependent of another person, you cannot claim qualifying individuals for yourself. You cannot claim a qualifying individual if they file a joint tax return with their spouse. Only the custodial parent of divorced or legally-separated parents can be reimbursed using the Dependent Care FSA.

What is my maximum annual deposit?

- If you are married and filing separately, your maximum annual deposit is \$2,500.
- If you are single and head of household, your maximum annual deposit is \$5,000.
- If you are married and filing jointly, your maximum annual deposit is \$5,000.
- If either you or your spouse earn less than \$5,000 a year, your maximum annual deposit is equal to the lower of the two incomes.
- If your spouse is a full-time student or incapable of self-care, your maximum annual deposit is \$3,000 a year for one dependent and \$5,000 a year for two or more dependents.

When are my funds available?

Once you sign up for a Dependent Care FSA and decide how much to contribute, the funds available to you depend on the actual funds in your account. Unlike a Healthcare FSA, the entire maximum annual amount is not available during the plan year, but rather after your payroll deductions are received.

Should I claim tax credits or exclusions?

Since money set aside in your Dependent Care FSA is always tax free, you guarantee savings by paying for your eligible expenses through your IRS tax-favored account. Depending on the amount of income taxes you are required to pay, participation in a Dependent Care FSA may produce a greater tax benefit than claiming tax credits or exclusions alone.

Remember, you cannot use the dependent care tax credit if you are married and filing separately. Further, any dependent care expenses reimbursed through your Dependent Care FSA cannot be filed for the dependent care tax credit, and vice versa.

To help you choose between the available taxable and tax-free benefits, or a combination of both, consult your tax advisor and/or the IRS for additional information. You may also visit www.myFBMC.com to complete a Tax Savings Analysis.

Are some expenses ineligible?

Expenses not eligible for reimbursement through your Dependent Care FSA include:

- books and supplies
- child support payments or child care if you are a non-custodial parent
- health care or educational tuition costs and
- services provided by your dependent, your spouse's dependent or your child who is under age 19.

What is a Dependent Care FSA?

A Dependent Care FSA is an IRS tax-favored account you can use to pay for your eligible dependent care expenses to ensure your dependents (child or elder) are taken care of while you and your spouse (if married) are working. These funds are set aside from your salary before taxes are deducted, allowing you to pay your eligible expenses tax free. A partial list of these eligible expenses can be found on this page.

Whose expenses are eligible?

You may use your Dependent Care FSA to receive reimbursement for eligible dependent care expenses for qualifying individuals.

A qualifying individual includes a qualifying child, if they:

- are a U.S. citizen, national or a resident of the U.S., Mexico or Canada
- have a specified family-type relationship to you
- live in your household for more than half of the taxable year
- are 12 years old or younger and
- have not provided more than one-half of their own support during the taxable year.

A qualifying individual includes your spouse, if they:

- are physically and/or mentally incapable of self care
- live in your household for more than half of the taxable year and
- spend at least eight hours per day in your home.

A qualifying individual includes your qualifying relative, if they:

- are a U.S. citizen, national or a resident of the U.S., Mexico or Canada
- are physically and/or mentally incapable of self care
- are not someone else's qualifying child
- live in your household for more than half of the taxable year and

Dependent Care FSA

Will I need to keep any additional documentation?

To claim the income exclusion for dependent care expenses on IRS Form 2441 (Child and Dependent Care Expenses), you must be able to identify your dependent care provider. If your dependent care is provided by an individual, you will need their Social Security number for identification, unless he or she is a resident or non-resident alien who does not have a Social Security number. If your dependent care is provided by an establishment, you will need its Taxpayer Identification number.

If you are unable to obtain a dependent care provider's information, you must compose a written statement that explains the circumstances and states that you made a serious and earnest effort to get the information. This statement must accompany your IRS Form 2441.

When do I request reimbursement?

You can request reimbursement from your Dependent Care FSA as often as you like. However, your approved expense will not be reimbursed until the last date of service for which you are requesting reimbursement has passed. Also, remember that for timely processing of your reimbursement, your payroll contributions must be current.

Be certain you obtain and submit all needed information when requesting reimbursement from your Dependent Care FSA. This information is required with each request for reimbursement.

A properly completed request will help speed along the process of your reimbursement, allowing you to receive your check or Direct Deposit promptly.

How do I request reimbursement?

Requesting reimbursement from your Dependent Care FSA is easy. Simply mail or fax a correctly completed FSA Reimbursement Request Form along with documentation showing the following:

- the name, age and grade of the dependent receiving the service
- the cost of the service
- the name and address of the provider and
- the beginning and ending dates of the service.

Be certain you obtain and submit the above information when requesting reimbursement from your Dependent Care FSA. This information is required with each request for reimbursement.

Mail to:

Fringe Benefits Management Company
P.O. Box 1800
Tallahassee, FL 32302-1800

Fax to: 866-440-7154

Note: If you elect to participate in the Dependent Care FSA, or if you file for the Dependent Care Tax Credit, you must attach IRS Form 2441, reflecting the information above, to your 1040 income tax return. Failure to do this may result in the IRS denying your pre-tax exclusion.

Appeals Process for Denied FSA Claims

If you have a request for an FSA reimbursement claim or other similar request denied, in full or in part, you have the right to appeal the decision by sending a written request to FBMC for review within 30 days of the denial.

Your appeal must include:

- the name of your employer
- the date of the services for which your request was denied
- a copy of the denied request
- the denial letter you received
- why you think your request should not have been denied and
- any additional documents, information or comments you think may have a bearing on your appeal.

Your appeal will be reviewed upon receipt of it and its supporting documentation. You will be notified of the results of this review within 30 business days from receipt of your appeal. In unusual cases, such as when appeals require additional documentation, the review may take longer than 30 business days. If your appeal is approved, additional processing time is required to modify your benefit elections.

Note: Appeals are approved only if the extenuating circumstances and supporting documentation are within your employer's, insurance provider's and IRS regulations governing the plan.

FSA Worksheets

To figure out how much to deposit in your FSA, refer to the following worksheets. Calculate the amount you expect to pay during the plan year for eligible, uninsured out-of-pocket medical and/or dependent care expenses. This calculated amount cannot exceed established IRS and plan limits. (Refer to the individual FSA descriptions in this Reference Guide for limits.)

Be conservative in your estimates, since any money remaining in your accounts cannot be returned to you or carried forward to the next plan year.

HEALTHCARE FSA WORKSHEET

Estimate your eligible, uninsured out-of-pocket medical expenses for the plan year.

UNINSURED MEDICAL EXPENSES

Health insurance deductibles	\$ _____
Coinsurance or co-payments	\$ _____
Vision care	\$ _____
Dental care	\$ _____
Prescription drugs	\$ _____
Travel costs for medical care	\$ _____
Other eligible expenses	\$ _____

TOTAL

Estimated uninsured expenses for your period of coverage during the plan year. Amount cannot exceed \$4,949.04.

\$ _____

DIVIDE by the number of paychecks you will receive during the plan year (26).*

\$ _____

This is your pay period contribution.

\$ _____

Remember to review your first paycheck to be certain the correct amount has been reduced from your salary (\$190.34 maximum per pay period).

* If you are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year.

DEPENDENT CARE FSA WORKSHEET

Estimate your eligible dependent care expenses for the plan year. Remember that your calculated amount cannot exceed the calendar year limits established by the IRS.

CHILD CARE EXPENSES

Day care services	\$ _____
In-home care/au pair services	\$ _____
Nursery and preschool	\$ _____
After school care	\$ _____
Summer day camps	\$ _____

ELDER CARE SERVICES

Day care center	\$ _____
In-home care	\$ _____

TOTAL

Estimated uninsured expenses for your period of coverage during the plan year. Amount cannot exceed \$4,949.04.

\$ _____

DIVIDE by the number of paychecks you will receive during the plan year (26).*

\$ _____

This is your pay period contribution.

\$ _____

Remember to review your first paycheck to be certain the correct amount has been reduced from your salary (\$190.34 maximum per pay period).

* If you are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year.

Your annual FSA administrative fee is \$50.96, regardless of which type of account you select. However, even if you select both accounts, your total fee will not exceed \$50.96.

At your request, your FSA reimbursement checks may be deposited into your checking or savings account by enrolling in Direct Deposit.

Changing Your Coverage

Am I permitted to make mid-year election changes?

Under some circumstances, your employer's plan(s) and the IRS may permit you to make a mid-year election change or vary a salary reduction amount, depending on the qualifying event and requested change. The benefit addition or deletion must have a direct relationship to the qualifying event. For example, if an employee's spouse and child were covered for medical and dental coverage only through the spouse's employer but the spouse terminated employment, (therefore losing eligibility for continued group coverage) the employee may add their spouse and/or child to the County's medical and/or dental plan within 45 days of the spouse/child losing eligibility for insurance benefits. However, this would not be a qualifying event for the County employee to enroll in or increase their healthcare or dependent care spending account, since the spouse was not enrolled for such benefits through their former employer at the time of termination.

New Qualifying Event under CHIPRA

CHIPRA (Children's Health Insurance Program Reauthorization Act) legislation enacted in 2009, creates special enrollment rights beginning with the new plan year, for dependents that lose or become eligible for coverage under Medicaid (or State sponsored health plan). How does this affect you? Previously, under IRS Section 125 provisions, losing eligibility under Medicaid or State plan (such as Florida KidCare) was considered a qualifying event, allowing dependent enrollment under the employer's health plan. However, the reverse (cancelling dependents from employer's plan as a result of child gaining eligibility under Florida KidCare), was not permitted under IRS Section 125 until now. Additionally, the reporting grace period for these two qualifying events (losing and gaining eligibility under Medicaid or State plan) has increased to sixty (60) days. This legislation does not affect the grace period for the other qualifying events under the County's program, which continue to be forty-five (45) days (except for the addition of newborns, or adoption/placement for adoption, which continues to be sixty days).

How do I make a change to my health plan mid year?

You may add or delete dependents to your health plan during the plan year only under limited circumstances. A partial list of permitted changes appear on the following page. Election changes must be consistent with the event. Mid-year changes from one health plan to another, are not permitted.

To Make a Change: Within 45 days (60 days to add newborns) of a qualifying event, you must complete and submit a Flexible Benefits Change in Status (CIS) Form and Health Plan Status Change Form to your Department Personnel Representative (DPR). These forms may be obtained online at the benefits website. Documentation supporting your election change request is required. Do not delay submission of your Change in Status and Health Plan Status Change Forms while you gather your documentation. Simply forward the forms to your DPR and present your documentation as soon as it becomes available.

Upon the approval and completion of processing your election change request, your existing elections will be stopped or modified (as appropriate). Generally, mid-year pre-tax election changes can only be made prospectively, no earlier than the beginning of the pay period after your election change request has been received by the Benefits Administration Unit (BAU), unless otherwise provided by law. Changes to add a new dependent become effective the first day of the month following receipt of a timely request with the exception of birth, adoption or placement for adoption which become effective as of birth or *the earlier of*: a) adoption or b) placement for adoption. Payroll changes to add a newborn are processed in accordance with Florida statute 641.31(9). If the CIS form is received by BAU within the first thirty-one (31) days from birth, the premium is waived for the first 31 days. If the CIS form is received after the first 31 days, but within sixty (60) days of the event, the new premium will be charged retroactive to the date of birth. The same applies when adding an adopted child or child placed for adoption. The premium is waived if the CIS form is received by BAU

within the first thirty-one (31) days from *the earlier of*: a) adoption or b) placement for adoption. If the CIS form is received after the first 31 days, but within 60-days of the event, the new premium will be charged retroactive to *the earlier of*: a) adoption or b) placement for adoption. Payroll changes to delete a dependent, other than those events specified in this paragraph, become effective the first day of the pay period following receipt by the Benefits Administration Unit.

If a request to delete an ineligible dependent is received after the 45-day deadline, the dependent's coverage will be cancelled, but the dependent premium will continue through the end of the plan year.

How do I make an FSA change?

You can change your Flexible Spending Account (FSA) election(s), or vary the salary reduction amounts you have selected during the plan year, only under limited circumstances. A partial lists of permitted qualifying events under your employer's plan(s) appear on the following page. For example: if you get divorced, an IRS special consistency rule allows you to lower or cancel your Healthcare FSA coverage for the individual involved. The Benefits Administration Unit (BAU) of Risk Management, General Administration Unit will review on a uniform and consistent basis, the facts and circumstances of each properly completed and timely submitted mid-plan year election change form.

What are the IRS Special Consistency Rules governing Changes in Status?

- 1. Loss of Dependent Eligibility** - If a change in your marital or employment status involves a decrease or cessation of your spouse's or dependent's eligibility requirements for coverage due to: your divorce, your spouse's or dependent's death or a dependent ceasing to satisfy eligibility requirements, you may decrease or cancel coverage only for the individual involved. You cannot decrease or cancel any other individual's coverage under these circumstances.
- 2. Gain of Coverage Eligibility Under Another Employer's Plan** - If you, your spouse or your dependent gains eligibility for coverage under another employer's plan as a result of a change in marital or employment status, you may cease or decrease that individual's coverage if that individual gains coverage, or has coverage increased under the other employer's plan.
- 3. Dependent Care Expenses** - You may change or terminate your Dependent Care FSA election when a Change in Status (CIS) event affects (i) eligibility for coverage under an employer's plan, or (ii) eligibility of dependent care expenses for the tax exclusion available under IRC § 129.

Appeals Process for Denied Change in Status Requests

If you have a request for a Change in Status denied, you have the right to appeal the decision by sending a written request within 30 days of the denial for review to the Benefits Administration Unit of Risk Management, GSA. Your appeal must include:

- a copy of the denied request
- the denial letter you received
- why you think your request should not have been denied and
- any additional documents, information or comments you think may have a bearing on your appeal.

Your appeal will be reviewed and you will be notified of the results of this review within 30 business days from receipt of your appeal. In unusual cases, such as when appeals require additional documentation, the review may take longer than 30 business days. If your appeal is approved, additional processing time is required to modify your benefit elections.

Note: Appeals are approved only if the extenuating circumstances and supporting documentation are within your employer's, insurance provider's and IRS regulations governing the plan.

Changing Your Coverage (Qualifying Events)

Mid-Year Permitted Changes in Status:

Marital Status	A change in marital status includes marriage, death of a spouse, divorce or annulment (legal separation is not recognized in all states).
Change in Number of Tax Dependents	A change in number of dependents includes the following: birth, death, adoption and placement for adoption. You can add existing dependents not previously enrolled whenever a dependent gains eligibility as a result of a valid CIS event.
Change in Status of Employment Affecting Coverage Eligibility	Change in employment status of the employee, or a spouse or dependent of the employee, that affects the individual's eligibility under an employer's plan includes commencement or termination of employment.
Gain or Loss of Dependents' Eligibility Status	An event that causes an employee's dependent to satisfy or cease to satisfy coverage requirements under an employer's plan may include change in age, student, marital, employment or tax dependent status.
Change in Residence*	A change in the place of residence of the employee, spouse or dependent that affects eligibility to be covered under an employer's plan includes moving out of an HMO service area.
Coverage and Cost Changes*	Your employer's plans may permit election changes due to cost or coverage changes. You may make a corresponding election change to your Dependent Care FSA benefit whenever you actually switch dependent care providers. However, if a relative (who is related by blood or marriage) provides custodial care for your eligible dependent, you cannot change your salary reduction amount solely on a desire to increase or decrease the amount being paid to that relative.
Open Enrollment Under Other Employer's Plan*	You may make an election change when your spouse or dependent makes an Open Enrollment Change in coverage under their employer's plan if they participate in their employer's plan and: <ul style="list-style-type: none"> • the other employer's plan has a different period of coverage (usually a plan year) or • the other employer's plan permits mid-plan year election changes under this event.
Judgment/Decree/Order†	If a judgment, decree or order from a divorce, legal separation (if recognized by state law), annulment or change in legal custody requires that you provide accident or health coverage for your dependent child (including a foster child who is your dependent), you may change your election to provide coverage for the dependent child. If the order requires that another individual (including your spouse and former spouse) covers the dependent child and provides coverage under that individual's plan, you may change your election to revoke coverage only for that dependent child and only if the other individual actually provides the coverage.
Medicare/Medicaid†	Gain or loss of Medicare/Medicaid coverage may trigger a permitted election change.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	If your employer's group health plan(s) are subject to HIPAA's special enrollment provision, the IRS regulations regarding HIPAA's special enrollment rights provide that an IRC § 125 cafeteria plan may permit you to change a salary reduction election to pay for the extra cost for group health coverage, on a pre-tax basis, effective retroactive to the date of the CIS event, if you enroll your new dependent within 45 days (60 days to add newborns) of one of the following CIS events: birth, adoption or placement for adoption. Note that a Medical Expense FSA is not subject to HIPAA's special enrollment provisions if it is funded solely by employee contributions.
Family and Medical Leave Act (FMLA) Leave of Absence	Election changes may be made under the special rules relating to changes in elections by employees taking FMLA leave. Contact your employer for additional information.
Unpaid Leave of Absence	You may submit a completed Flexible Benefits Change in Status Form and Insurance Status Change form within 45 days of being in a leave without pay status to temporarily cancel your health insurance coverage. Upon return to pay status (within 45 days), you must re-submit a completed Flexible Benefits Change in Status form and Insurance Status Change Form to your DPR to reinstate coverage.

* Does not apply to a Medical Expense FSA plan.

† Does not apply to a Dependent Care FSA plan.

ARAG Legal Plan

Without a legal plan, attorney services can be expensive - averaging \$286 per hour.* That's why we want to give you easy and affordable access to professional attorneys for a wide array of legal needs.

(*Average attorney rates in the United States of \$286 per hour for attorneys with 11 to 15 years of experience," Survey of Law Firm Economics, Altman Weil Publications, Inc., 2007.)

Are my premiums tax-free?

No. Your premiums will be deducted from your paycheck after taxes have been calculated.

Eligible Expenses Coverage

In-Office Legal Representation: When you have a legal need that requires legal representation, you can meet with an attorney in the attorney's office or in the courtroom to get the legal help and protection you need. Attorney fees for most covered matters are 100% paid-in-full when you work with a Network Attorney. For a complete list of coverages, please refer to pages 42 and 43.

Telephone Legal Advice and Consultation: Attorneys can easily handle certain issues over the phone. You can consult with a Network Attorney over the phone as often as necessary - and as long as necessary - for any of the following legal needs:

- General Legal Advice and Consultation
- Standard Will Preparation
- Living Will and Durable Powers of Attorney Preparation
- Small Claims Assistance
- Follow-up Calls and Letters
- Specific Document Preparation
- Document Review; up to four pages

Reduced Fee Services: If you need legal representation for a legal situation that's not covered under the plan, but not specifically excluded, you can still save money by using an attorney for a Reduced Fee Benefit. Network Attorneys can provide a reduced fee of at least 25% off their normal hourly rate for legal matters.

Online Legal Tools and Resources: Simply want to research a certain legal topic in the comfort of your own home? With UltimateAdvisor, it can be as simple as going online to your Legal Benefits Web Site to access:

- Law Guide of easy-to-understand legal articles to help you research and learn more about your legal situation.
- Hundreds of Do-It-Yourself Legal Documents™, for when you want the convenience and control of preparing a variety of legal documents yourself.

Identity Theft Services: As a member, you have toll-free access to Certified Identity Theft Case Managers to help get your life back in order and repair any damage done to your identity. The case managers will:

- Explain what identity theft is and how to prevent it
- Provide resources to minimize and recover from identity theft
- Explain relevant plan coverages
- Provide an identity theft prevention kit
- Provide an identity theft victim action kit
- Monitor the resolution of the situation

Immigration Assistance: A service that gives you toll-free access to Telephone Network Attorneys for legal advice and consultation on:

- Immigration processes and guidelines.
- Filing and processing of applications or Petitions.
- Laws and regulations governing various types of immigration benefits; including asylum, adjustment of status, business visas and employment authorizations.
- Deportation and removal proceedings.

For additional immigration services, Network Attorneys provide a reduced rate of at least 25% off their normal rates for any document review, preparation or representation-based immigration services. Network Attorneys will bill the member directly.

Financial Education and Counseling Services: Experienced financial counselors are available over the phone. Counselors are committed to offering you a level of awareness and confidence to effectively manage your finances on topics such as cash and debt management, budgeting, financial planning, federal tax information and education, Social Security, Medicare, retirement planning, individual retirement accounts (IRAs), investment planning and stock options. You can also receive access to an Interactive Financial Planning web site that offers:

- A Personalized Financial Plan
- Online Courses
- Life Events Guides and Financial Articles
- A Step-by-Step Financial Action Plan

ARAG Legal Plan

In-Office Legal Representation

Coverage

Network Attorney

Non-Network Attorney* Amount Reimbursed

Consumer Protection

Paid in full

\$2,200**

Representation in a legal action required for the enforcement of written or implied warranties or promises relative to the lease or purchase of goods or services (except structural damage) is available. Actual amount in dispute must be at least \$500.

Consumer Debt Collection Defense

Paid in full

\$2,200**

Defense of lawsuit based upon a contract or written instrument is available.

Adoption Proceedings

Paid in full

\$300*

Uncontested Guardianship/Conservatorship

Paid in full

\$300*

Insanity or Infirmity Proceedings

Paid in full

\$2,200**

Name Change

Paid in full

\$240*

Juvenile Court Proceedings Involving an Insured Child

Paid in full

\$2,080**

Service does not include proceedings involving traffic matters.

Habeas Corpus Court Proceedings

Paid in full

\$300*

Estate Planning (Wills)

Individual Simple Will

Paid in full

\$100

Husband and Wife Simple Wills

Paid in full

\$125

(including Powers of Attorney and Ordinary Trust Provisions)

Codicil

Paid in full

\$60

Wills with other than Ordinary Trust Provisions

Paid in full (up to 6 hours)

\$300*

Living Will

Paid in full

\$60

Durable Power of Attorney

Paid in full

\$60

IRS Audit Protection

Legal services involving personal tax IRS audits for which you receive written notice while your certificate of insurance is in effect and which relate to your personal federal tax return.

Advice consultation and negotiation

\$420*

\$420*

Representation at IRS audit

\$900*

\$900*

IRS Collection Defense

Legal defense against collection actions by the Internal Revenue Service regarding a members personal federal tax return is available. The member must receive written notice while his/her Certificate of Insurance is in effect.

Legal Services and court representation prior to trial

\$1,800**

\$1,800**

Court representation at trial as a defendant

\$1,600**

\$1,600**

Estate Administration and Estate Closing

Legal assistance is provided to you in administering an insured's bequest which you inherit while your Certificate of Insurance is in effect.

Advice, office work and/or the applicable property transfers and court appearances.

\$500*

\$500*

Administrative Hearings

Paid in full

\$1,200*

The services cannot be related to insured's employment, but includes advice and document preparation related to an Insured's Immigration Proceedings.

Major Trial

Paid in full

\$5,000***

Preventive Legal Services

Paid in full

\$360*

Six hours each plan year per family for office advice, negotiation and document preparation and review (e.g., leases, promissory notes, demand letters, affidavits, deeds and mortgages)

Real Estate Matters

Paid in full

Sale \$360*

Representation of insured in the sale or purchase of a principal residence (benefit limited to one sale or one purchase per plan year)

Purchase \$240*

ARAG Legal Plan

In-Office Legal Representation (cont.)

Coverage

Network Attorney

Non-Network Attorney* Amount Reimbursed

The following benefits are effective only after a six-month waiting period.

Personal Bankruptcy	Paid in full	\$420*
Dissolution of Marriage (employee only)		
Divorce, legal separation or annulment		
Uncontested	Paid in full	\$420*
Contested	Paid in full (up to 20 hours per event)	\$1,080*
Defense of a motion to modify a final divorce decree	Paid in full	\$360*

In-office legal representation is limited to one usage per family per plan year.

* Non-Network Attorney coverage is \$60 per hour up to the stated amount.

** Trial Indemnity benefits of \$1,600 for up to three days of trial time are included in this amount (\$200 per ½ day of trial time).

*** Major Trial time is paid at the rate of \$200 per ½ day of trial time.

What's Not Covered?

This is not a complete list of limitations and exclusions

- Actions or disputes between you and your employer, or your employer's insurance carrier, unions, plan underwriter and any party when coverage is prohibited by law
- Workers' Compensation, Unemployment Compensation, Class Actions, Interventions and Amicus Curiae
- Matters relating to patents, copyrights or appeal proceedings
- Duplication of services previously claimed in relation to same matter
- Probating of estates, title insurance, title search, title abstracting, filing fees, reporter's fees and court costs
- Services regarding matters resulting from your occupation, including business interests, transactions, pursuits and partnerships
- Any legal matter which occurs or is initiated prior to your effective date of coverage (This includes the dates for which an infraction occurs, a document is filed with the court or an attorney is hired.)
- Preparing, completing, or filing of a federal, state, or local tax return
- Contingency fee cases and similar matters for which a fee is normally allowed by law
- Any action brought in Small Claims Court
- Any legal proceeding in which you are entitled to legal representation or reimbursement for the costs thereof from any source other than this policy or another legal expense policy
- Matters related to structural damage to dwellings, appurtenances and paved surfaces

If you are unsure whether a matter is covered, contact ARAG at 800-247-4184 and a Customer Care Specialist will provide you information on limitations and exclusions.

Who are my eligible dependents?

- Your spouse or domestic partner.
- All unmarried dependent children or children of a domestic partner to the end of the calendar year turning 19. Coverage may be extended to the end of the calendar year turning 25 if the unmarried dependent child is a full-time or part-time student or residing in the employee's household.

Important Note

If you elect coverage for yourself and one dependent, the first dependent for whom you file a claim will be considered the only dependent covered under this plan. Changes to the plan, outside of the annual open enrollment period, are allowed only if a corresponding qualifying event is experienced and a timely request is made.

Terminated employees may purchase a conversion policy by directly contacting ARAG, at 800-247-4184.

Plan Provider

ARAG is to global provider of legal insurance. ARAG Insurance Company is rated A (Excellent) by A.M. Best Company.

Insurance products are underwritten by ARAG Insurance Company of Des Moines, Iowa or GuideOne Mutual Insurance Company of West Des Moines, Iowa or GuideOne Specialty Mutual Insurance Of West Des Moines Iowa. Service products are provided by ARAG LLC, ARAG Services LLC, or Advisory Communication Systems Inc. depending on the product and state. Some products are only available through membership in the ARAG Association LC.

This material is for illustrative purposes only and is not a contract. For terms, benefits and exclusions, call ARAG toll free at 800-247-4184.

Your After-tax Rates

Level of Coverage	Biweekly Premium
Employee Only	\$ 7.37
Employee & One Dependent	\$ 9.45
Employee & Family	\$ 9.72

To locate Participating Attorneys

You may visit your Legal Benefits Web Site at: <http://members>.

ARAGgroup.com/MDCounty to view a list of Network Attorneys and plan benefits or contact ARAG at 800-247-4184.

Deferred Compensation Plan

When you retire, you'll want to maintain the lifestyle you currently have. Social Security and the Florida Retirement System are not intended to replace all of your income at retirement. It is wise to start a savings plan now. The Deferred Compensation Plan is a tax-deferred savings plan that can be used at retirement to supplement your Florida Retirement System and Social Security benefits.

Eligibility

All Miami-Dade County employees are eligible to participate in this plan. There is no waiting period or minimum number of hours you must work biweekly.

Plan Features

- Contributions are made to your deferred compensation account through payroll deductions. Note, the contribution limits are based on IRS allowances as of the printing of this book. Visit the benefits website for updates.
- Contributions are taken from your gross salary before Federal Withholding taxes are calculated.
- Your contributions are invested in the products of your choice.
- You don't pay Federal Withholding Income taxes on your investment contributions or earnings until you receive the money.
- Social Security taxes on contribution amounts continue to be deducted from your gross salary.
- This plan is governed by Section 457 Internal Revenue Code.

What happens to the money I contribute?

You choose between two providers, ICMA-RC or National Association of Counties (NACo), administered by Nationwide Retirement Solutions (NRS). You may contribute to both providers if you wish, as long as you do not exceed the total maximum annual contribution.

Each provider offers a number of investment options, including fixed funds, stock funds, bond funds, mutual funds and others. You may wish to seek the advice of an accountant or other professional for investment assistance.

Both ICMA-RC and NRS have representatives available to meet with plan participants one-on-one to discuss your financial objectives. Contact your DPR for the name and telephone number of the plan representative(s) assigned to your department. In addition, onsite representatives are available in the Benefits Administration Unit. Please see page 2 of this Handbook for times and contact information.

Payouts

- Once you retire or separate employment, you become eligible for payments from your account. There is neither a minimum age requirement nor a waiting period for you to begin receiving payments.
- You are not required to select a payout commencement date. At the time you are ready to begin receiving your payout, simply contact your plan provider.
- Once you are eligible to receive payments, you may select from a variety of payment options. You may receive a lump sum, installment payments, irregular payments or guaranteed monthly payments for life.
- You may rollover funds from another eligible retirement plan, your FRS DROP account, or IRA into the 457 plan. You may also rollover your 457

funds into another eligible retirement plan or to an IRA. Please consult with your tax professional for guidance.

"Catch-up" Provision

If you are within three years prior to the year you designate for normal retirement, you may be eligible to take advantage of a special "catch-up" provision which may allow you to contribute up to \$33,000. You may not participate in the "catch-up provision" beyond age 70½. Additionally, there is an age 50 "catch-up" provision that permits an employee to contribute an extra \$5,500 per year, if at least age 50. You may not utilize both "catch-up" provisions simultaneously. Contact the Benefits Administration Unit at 305-375-5633 or 305-375-4288 or the on site deferred compensation plan representative for more information.

Unforeseeable Emergency Withdrawal

You may be able to withdraw money from your account while you are still working if you have an unforeseeable emergency. An unforeseeable emergency is a severe financial hardship to the participant resulting from a sudden and unexpected illness or accident of the participant or of a dependent of the participant, loss of the participant's property due to casualty or other similar extraordinary circumstances arising as a result of events beyond the control of the participant. The amount of money you could receive is limited to the amount necessary to relieve the hardship.

An Unforeseeable Emergency withdrawal is very difficult to receive, and you should not depend on the availability of your funds. Some examples of an Unforeseeable Emergency are health care and property losses due to theft or fire, which are not covered by insurance.

Employees can contact their provider directly to request an emergency withdrawal packet.

Loan Provision

The deferred compensation plan allows participants to borrow up to 50% of their plan balance, not to exceed \$50,000. Employees can take one of two types of loans: 1) To purchase a primary residence, or 2) A general loan. The maximum repayment term for a primary residence is 15 years and for a general loan, it's 5 years. For employees participating in both plans, the \$50,000 limit is the combined maximum. For additional information, contact your plan provider directly.

2010 Biweekly Minimum Contribution: \$10 per pay period
2010 Annual Maximum Contribution: 100% of your gross taxable salary or \$16,500 (whichever is less)

Benefit available to eligible Retired Public Safety Officers

One of the provisions of the Pension Protection Act of 2006 permits 457(b) plans to provide up to \$3,000 in pre-tax treatment for insurance premium payments that are deducted from the retired public safety officer's 457(b) account and paid directly to the insurance provider. Upon retirement, please contact the deferred compensation provider for further information. If you are like most people, you want to make sure that your loved ones are adequately provided for should something happen to you.

Group Term Life Insurance

Basic Life

The County provides you with group term life insurance equal to your annual adjusted base salary.

Plan Features

- Benefits are payable for death from any cause to the beneficiaries you name.
- Beneficiary designations may be updated at any time.
- If death results from accidental injuries, your beneficiary may be eligible to receive Group Accidental Death and Dismemberment Insurance (AD&D) equal to your annual base salary.
- Dismemberment benefits, up to the same amount as your group term basic life coverage, are payable for loss of hand, foot or sight of eye resulting from an accident. See your policy for plan provisions.
- Employee must be actively at work for coverage to start.

How to enroll for basic life coverage

New employees will be automatically enrolled for the County-paid basic life insurance upon enrolling for health or flex benefits online at <http://enet.miamidade.gov>, during their initial eligibility period. Select the New Hire Benefits Enrollment link to enroll for desired benefits and then go to the Beneficiary Designation link to list your beneficiaries for life insurance death benefits. The link is accessible 24/7 from any computer. You can also change your beneficiaries anytime using the eNet Beneficiary Designation link.

Employees who currently do not have life insurance coverage (either failed to apply during their initial eligibility period, or lost the coverage due to non-payment of premiums during an unpaid leave of absence), will not be able to enroll online. Contact your Department Personnel Representative for information regarding the evidence of insurability process and complete the MetLife Statement of Health (SOH) form for basic life insurance coverage. The application is subject to medical approval and may be denied. If approved, you must be actively at work for the coverage to be effective.

DCFF Fire Union-sponsored plan enrollees who change to a County sponsored medical/dental plan during the open enrollment period must complete a MetLife Life Insurance medical statement of health (SOH) to be considered for life insurance. Life insurance is subject to medical approval and may be denied. Basic Life Insurance through the DCFF plan will cease as of the open enrollment effective date.

Group Term Optional Life Insurance

Although the County assumes the full cost for your basic life insurance with MetLife, you may purchase additional coverage or, "Optional Life Insurance." Employees applying within their eligibility period, or 30 day grace period, may enroll for up to three times annual adjusted salary without evidence of insurability. All other amounts are subject to evidence of insurability.

Plan Features

- If interested, you should elect coverage at the time you sign up for group medical, dental, vision and/or basic life benefits.

- You may apply for coverage up to five times your annual adjusted base salary.
- Premiums are age-based and depend on the amount of coverage purchased. Contact your Departmental Personnel Representative or the Benefits Administration Unit at 305-375-5633 or 305-375-4288 for further details. Visit the online premium calculator at <http://www.miamidade.gov/benefits> and check on left navigation link for Calculator.
- **You may reduce the level of coverage or cancel coverage at any time. However, if you wish to re-enroll for coverage or increase the level of coverage, you must submit an application during the annual Optional Life Open Enrollment. Coverage is subject to medical approval.**
- Life insurance amounts in excess of \$50,000 may be taxable and may be included as taxable income on your W-2 form. See the Beyond Your Benefits section for further details.
- Free will preparation services are offered by Hyatt Legal Plans, a MetLife company. To utilize this service or for further assistance, contact Hyatt Legal Plans Toll Free at 1-800-821-6400, provide them with the Miami-Dade County Group Number 25800 and your social security number.
- An employee must be actively at work for coverage to begin. This also applies to increases in coverage.

How to Enroll for Group Term Optional Life Coverage

When first eligible, new employees may apply for optional life coverage using the County's eNet portal at <http://enet.miamidade.gov>. Select the New Hire Benefits Enrollment link to enroll, and then go to the Beneficiary Designation link to list your beneficiaries for life insurance death benefits. The link is accessible 24/7 from any computer. You can also change your beneficiaries anytime using the eNet Beneficiary Designation link. If you don't enroll during your initial eligibility period, an Optional Life open enrollment is held once a year in the spring at <http://metlife.com/mybenefits>. You may submit an online application during this period, but it will be subject to medical approval. You must be actively at work for coverage to be effective.

Other benefits provided by Miami-Dade County

In addition to the group medical, dental and vision plans, Flexible Benefits Plan, and Group Legal Services, your benefits package also includes:

- Paid annual and sick leave
- 13 paid holidays
- Membership in either of the Florida Retirement System (FRS) plans
- Workers' Compensation
- Unemployment Compensation
- Social Security
- Employee Discount Program
- Tuition Refund and
- County Death Benefit.

COBRA Q&A

IMPORTANT INFORMATION ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS

What is continuation coverage?

Federal law requires that most group health plans, including Healthcare Flexible Spending Accounts (Healthcare FSAs), give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee covered under the group health plan, a covered employee's spouse, and dependent children of the covered employee. Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including special enrollment rights. Specific information describing continuation coverage can be found in the Plan's summary plan description (SPD), which can be obtained from your health plan or FBMC. Domestic partners and their dependents are not eligible for coverage continuation under COBRA law. Refer to page 6 for information regarding continuation of coverage for domestic partner dependents.

COBRA information packets are sent by the insurance carriers to terminating employees within fourteen (14) days of notification of termination from County service. The County's notification to the plans is through a biweekly listing issued after the employee's department processes the termination through the payroll system. Group medical, dental, vision and basic/optional life insurance coverage (if enrolled) ceases the last day of the pay period in which the termination date falls and for which the employee experiences a regular insurance deduction or made direct payments to the Benefits Administration Unit (if on an unpaid leave of absence). If you exercise your rights under COBRA, upon receipt of your initial premium the insurance plan will reinstate your coverage retroactive to the group benefits termination date (without a gap). The HIPAA certificates will be issued by your medical insurance carrier, at the same time the COBRA notice is issued. For more information, please contact the insurance carrier. The employee or a family member has the responsibility of directly informing the Benefits Administration Unit of a divorce, or a child losing dependent status. Requests must be made on a timely basis (no later than 45 days from the qualifying event).

Basic/optional life insurance coverage is not subject to COBRA. If covered under the basic or optional life plan, the terminating employee will have the opportunity to convert to a private policy without being subject to evidence of insurability and will receive a conversion notice by mail. Employees may convert up to the volume of life insurance in force at the termination of employment, or convert amounts as determined by the Metropolitan Life Insurance Company. To obtain the life insurance conversion rates, contact the insurance carrier at the phone number listed on the conversion notice.

How long will continuation coverage last?

FSAs

If you fund your Healthcare FSA entirely, you may continue your Healthcare FSA (on a post-tax basis) only for the remainder of the plan year in which your qualifying event occurs, if you have not already

received, as reimbursement, the maximum benefit available under the Healthcare FSA for the year. For example, if you elected a maximum Healthcare FSA benefit of \$1,000 for the plan year and have received only \$200 in reimbursement, you may continue your Healthcare FSA for the remainder of the plan year or until such time that you receive the maximum Healthcare FSA benefit of \$1,000. Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time.

If your employer funds all or any portion of your Healthcare FSA, you may be eligible to continue your Healthcare FSA beyond the plan year in which the qualifying event occurs and you may have open enrollment rights at the next open enrollment period. There are special contribution rules for employer-funded Healthcare FSAs. If you have questions about your employer-funded Healthcare FSA, call FBMC at 1-800-342-8017.

Health Plans

You will be able to continue medical, dental and vision for up to 18 months if you lose group coverage due to termination of employment or reduction in hours. If your covered dependent(s) lost group coverage (for example, due to divorce, your death or child reaching the limiting age), coverage may be continued for up to 36 months from the qualifying event. See your Summary Plan Description (SPD) or certificate of coverage for other COBRA-qualifying events and explanation of your COBRA rights.

How can you elect continuation coverage?

Each qualified beneficiary has an independent right to elect continuation coverage the latter of 60 days from the date of COBRA notice or qualifying event. For example, both the employee and the employee's spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their dependent children only. Additionally, payment must be received within **45 days** of COBRA election. A qualified beneficiary must elect coverage by the date specified on the COBRA Election Form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you.

Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Disclosure Notice - SSN

The Benefits Administration Unit, Risk management Division, General Services Administration is responsible for the administration of all employee benefits including medical, dental, vision, life, group disability income protection, group legal, deferred compensation, pension benefits, IRS Section 125 plans and executive benefits. All employee records are reported to the plans using social security numbers because it is imperative for us to be able to identify members properly and definitively, and to meet state and federal reporting requirements.

Social security numbers are **confidential and exempt** from public records requests under section 119.07(1), Florida Statutes, and Section 24(a), Article I of the Florida Constitution.

The Florida Public Records Law (specifically, section 119.07(5)2.a., Florida Statutes (2007), provides that Miami-Dade County must give you a written statement describing the law under which the County is collecting your Social Security Number. The law may specifically direct the County to collect your Social Security Number or the County finds that it is imperative to collect your Social Security Number.

Miami-Dade County, Risk Management Division, General Services Administration must collect your Social Security Number to perform its duties and responsibilities including;

1. Group insurance enrollment, eligibility and claims processing
2. Pension plan administration
3. FBMC Spending accounts reporting
4. Deferred compensation reporting
5. Group Legal reporting
6. Group Disability reporting
7. Facilitate tax reporting
8. Disclosure to contracted vendors in the normal course of business
9. Identifying and preventing fraud
10. Matching, identifying and retrieving information
11. Research activities

Beyond Your Benefits

TERMS AND CONDITIONS

Taxable Benefits and the IRS

Disability Income Protection - Disability benefits may be taxed when an employee becomes disabled depending on how the premiums were paid during the year of the disabling event. For example, if you purchased disability coverage with pre-tax premiums and/or nontaxable employer credits, any disability payments received under the plan will be subject to federal income and employment (FICA) tax. If premiums were paid with a combination of pre-tax and after-tax dollars, then any disability payments received under the plan will be taxed on a pro rata basis. If premiums were paid on a post-tax basis and a disability entitles you to receive payments, you will not be taxed on the money you receive from the plan. You can elect to have federal income tax withheld by the provider just as it is withheld from your wages. Consult your personal tax advisor for additional information.

FICA taxes will be withheld from any disability payments paid through six calendar months following the last calendar month in which you worked prior to becoming disabled. Thereafter no FICA or Medicare tax will be withheld.

Life Insurance Premiums and the IRS

According to IRS regulations, you can pay premiums tax free on your first \$50,000 of life insurance. You must pay tax on premiums for coverage exceeding \$50,000. The first \$50,000 limit includes any life insurance provided to employees by Miami-Dade County. Premiums for additional life insurance exceeding the IRS \$50,000 maximum must be paid for with after-tax money.

Disclaimer - Health Insurance Benefits Provided Under Health Insurance Plan(s)

Health Insurance benefits will be provided by the Health Insurance Plan(s). The types and amounts of health insurance benefits available under the Health Insurance Plan(s), the requirements for participating in the Health Insurance Plan(s), and the other terms and conditions of coverage and benefits of the Health Insurance Plan(s) are set forth from time to time in the Policies of the Health Insurance Plan(s). All claims to receive benefits under the Health Insurance Plan(s) shall be subject to and governed by the terms and conditions of the Health Insurance Plan(s) and the rules, regulations, policies, and procedures from time to time adopted.

Social Security

Social Security consists of two tax components: the FICA or OASDI component (the tax for old-age, survivors' and disability insurance) and the Medicare component. A separate maximum wage to which the tax is assessed applies to both tax components. There is no maximum taxable annual wage for Medicare. The maximum taxable annual wage for FICA is subject to federal regulatory change. If your annual salary after salary reduction is below the maximum wage cap for FICA, you are reducing the amount of taxes you pay and your Social Security benefits may be reduced at retirement time.

However, the tax savings realized through the Flexible Benefits Plan generally outweigh the Social Security reduction.

FBMC Privacy Notice

4/14/03

This notice applies to products administered by Fringe Benefits Management Company and its wholly-owned subsidiaries (collectively "FBMC"). FBMC takes your privacy very seriously. As a provider of products and services that involve compiling personal-and sometimes, sensitive-information, protecting the confidentiality of that information has been, and will continue to be, a top priority of FBMC. This notice explains how FBMC handles and protects the personal information we collect. Please note that the information we collect and the extent to which we use it will vary depending on the product or service involved. In many cases, we may not collect all of the types of information noted below. FBMC's privacy policy is as follows:

- I. We collect only the customer information necessary to consistently deliver responsive services. FBMC collects information that helps serve your needs, provide high standards of customer service and fulfill legal and regulatory requirements. The sources and types of information collected generally varies depending on the products or services you request and may include:
 - Information provided on enrollment and related forms - for example, name, age, address, Social Security number, e-mail address, annual income, health history, marital status and spousal and beneficiary information.

- Responses from you and others such as information relating to your employment and insurance coverage.
- Information about your relationships with us, such as products and services purchased, transaction history, claims history and premiums.
- Information from hospitals, doctors, laboratories and other companies about your health condition, used to process claims and prevent fraud.

- II. Under HIPAA, you have certain rights with respect to your protected health information. You have rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan in care of FBMC's Privacy Officer or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

Additional information that describes how medical information about you may be used and disclosed and how you can get access to this information is provided electronically on our Web site: www.myFBMC.com. You have a right to a paper copy at any time. Contact FBMC Customer Service at 1-800-342-8017.

- III. We maintain safeguards to ensure information security. We are committed to preventing unauthorized access to personal information. We maintain physical, electronic and procedural safeguards for protecting personal information. We restrict access to personal information to those employees, insurance companies and service providers who need to know that information to provide products or services to you. Any employee who violates our Privacy Policy is subject to disciplinary action.

- IV. We limit how, and with whom, we share customer information. We do not sell lists of our customers, and under no circumstances do we share personal health information for marketing purposes. With the following exceptions, we will not disclose your personal information without your written authorization. We may share your personal information with insurance companies with whom you are applying for coverage, or to whom you are submitting a claim. We also may disclose personal information as permitted or required by law or regulation. For example, we may disclose information to comply with an inquiry by a government agency or regulator, in response to a subpoena or to prevent fraud.

We will provide our Privacy Notice to current customers annually and whenever it changes. If you no longer have a customer relationship with us, we will still treat your information under our Privacy Policy, but we will no longer send notices to you. In this notice of our Privacy Policy, the words "you" and "customer" are used to mean any individual who obtains or has obtained an insurance, financial product or service from FBMC that is to be used primarily for personal or family purposes.

Notice of Administrator's Capacity

PLEASE READ: This notice advises Flexible Spending Account participants of the identity and relationship between Miami-Dade County and its Contract Administrator, Fringe Benefits Management Company (FBMC). FBMC is not an insurance company. FBMC has been authorized by your employer to provide administrative services for the Flexible Reimbursement Account plans offered herein. FBMC will process claims for reimbursement promptly. In the event there are delays in claims processing, you will have no greater rights in interest or other remedies against FBMC than would otherwise be afforded to you by law.

Written Certification

When enrolling in either or both FSAs, written notice of agreement with the following will be required:

- I will only use my FSA to pay for IRS-qualified expenses and only for my IRS-eligible dependents
- I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s) before seeking reimbursement from my FSA
- I will not seek reimbursement through any additional source and
- I will collect and maintain sufficient documentation to validate the foregoing.

Important Notice of Prescription Coverage & Medicare

2010 Important Notice About Your Prescription Drug Coverage and Medicare From Miami-Dade County To Active Employees & Dependents Participating in the Following County-Sponsored Health Plans

AvMed POS • AvMed High Option HMO • AvMed Low Option HMO • JMH High Option HMO • JMH Low Option HMO

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Miami-Dade County and prescription drug coverage for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Miami-Dade County has determined that the prescription drug coverage offered by the above listed County plans, on average for all plan participants, is expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. Beneficiaries leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your Miami-Dade County prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

Your current coverage pays for other health expenses, in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with Miami-Dade County and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may

have to wait until the following November to enroll.

For more information about your current prescription drug coverage, refer to your certificate of coverage issued by your medical insurance plan, or visit www.miamidade.gov/benefits

You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage...

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. More information about Medicare prescription drug plans is available from these places:

- Visit www.medicare.gov for personalized help.
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number).
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Last Updated: October 14, 2009

Name of Entity: Miami-Dade County

Contact-Position/Office: GSA Risk Management, Benefits Administration Unit

Address: 111 NW 1st Street, Suite 2340

Phone Number: (305) 375-4288, (305) 375-5633

Health Benefits Notice of Privacy Practices

MIAMI-DADE COUNTY HEALTH BENEFITS NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice describes how Miami-Dade County's (the "County's") medical and flexible spending account benefits programs, collectively referred to as the "Plans," may use and disclose Protected Health Information ("PHI" or "health information"). Protected Health Information is individually identifiable information about your past, present or future health or condition, health care services provided to you, or the payment for health services, whether that information is written, electronic or oral. This notice also describes your rights under federal law relating to that information. It does not address medical information relating to disability, workers' compensation or life insurance programs, or any other health information not created or received by the Plans.

HOW THE PLANS MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

For Treatment. While the Plans generally do not use or disclose your PHI for treatment, the Plans are permitted to do so if necessary. For example, the Plans may disclose PHI if your doctor asks for preauthorization for a medical procedure, the Plan may provide PHI about you to the company that provides preauthorization services to the Plan.

For Payment. The Plans may use and disclose your health information for payment of claims. Such purposes include, but are not limited to, eligibility, claims management, precertification or pre-authorization, medical review, utilization review, adjustment of payments, billing, and subrogation. For example, a detailed bill or an "Explanation of Benefits" may be sent to you or to the primary insured or "subscriber" by a third-party payor that may typically include information that identifies you, your diagnosis, and the procedures you received.

For Health Care Operations. The Plans may use and disclose health information about you regarding day-to-day Plan operations. Such purposes include, but are not limited to, business management and administration, business planning and development, cost management, customer service, enrollment, premium rating, care management, case management, audit functions, fraud and abuse detection, performance evaluation, professional training, provider credentialing, formulary development, and quality assurance or other quality initiatives. For example, the Plans may use or disclose information about your claims history for your referral for case management services, project future benefit costs, handle claims appeals or audit the accuracy of the claims processing performed by a third party payor.

To the Plan Sponsor. The Plans may disclose health information to the County, but the County has put protections in place to assure that the information will only be used for plan administration purposes, and never for employment purposes. For example, the County may become involved in resolving claim disputes or customer service issues.

As Required by Law. The Plan may use or disclose health information about you as required by state and federal law. For example, the Plan may disclose information for the following purposes:

- for judicial and administrative proceedings;
- to report information regarding victims of abuse, neglect, or domestic violence; and

- to assist law enforcement officials in the performance of their law enforcement duties.

To Business Associates. There are some services the Plan provides through contracts with business associates. We may disclose your health information to our business associates so that they can perform the jobs we have asked them to do, for example, claims payment or appeals on behalf of the County by a third-party payor and claims audits by third-party firms to assure contract compliance. To protect the privacy of your health information, we contractually require business associates to appropriately safeguard that information.

For Health-Related Products and Services. The Plans may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

For Public Health. Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities in the prevention or control of disease, injury, or disability, or for other activities relating to public health.

For Health Oversight. We may disclose your health information to a health oversight agency for activities authorized by law such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee benefit programs, other government regulatory programs and civil rights laws.

For Research. We may disclose your confidential information for research purposes, subject to strict legal restrictions.

To Personal Representatives and Some Relatives. We may use or disclose your information to a personal representative formally designated by you or designated by law or, under circumstances, to a close relative such as the subscriber primarily responsible for your coverage or the parent of a minor child.

For Health and Safety. Your health information may be disclosed to avert a serious threat to the health or safety of you or another person pursuant to applicable law.

For Governmental Functions. Specialized governmental functions such as the protection of public officials or reporting to various branches of the armed services may require the use or disclosure of your health information.

For Workers Compensation. We may disclose your health information to the extent authorized by and to the extent necessary to comply with laws and regulations relating to workers compensation or other similar programs established by law.

No Other Uses. Other uses and disclosures will be made only with your prior written authorization. You may revoke this authorization except to the extent a Plan has already made a disclosure in reliance on such authorization.

YOUR LEGAL RIGHTS

The federal privacy regulations give you the right to make certain requests regarding health information about you:

Right to Request Restrictions. You have the right to request that the Plan restrict its uses and disclosures of PHI in relation to treatment, payment, and health care operations. Any such request must be made in writing and must state the specific restriction requested and to whom

that restriction would apply. The Plan is not required to agree to a restriction that you request.

Right to Request Confidential Communications. You have the right to request that communications involving your PHI be provided to you at a certain location or in a certain way. Any such request must be made in writing. The Plans will accommodate any reasonable request if the normal method of communication would place you in danger.

Right To Access Your Protected Health Information. You have the right to inspect and copy your PHI maintained in a "designated record set" by the Plan. The designated record set consists of records used in making payment, claims adjudication, medical management and other decisions. The Plan may ask that such requests be made in writing and may charge reasonable fees for producing and mailing the copies. The Plan may deny such requests in certain cases.

Right to Request Amendment. You have the right to request that your PHI created by the Plan and maintained in a designated record set be amended, if that information is in error. Any such request must be made in writing and must include the reason for the request. If the Plan denies your request for amendment, you may file a written statement of disagreement. The Plan has the right to issue a rebuttal to your statement, in which case, a copy will be provided to you.

Right to Receive An Accounting of Disclosures. You have the right to receive an accounting of all disclosures of your PHI that the Plan has made, if any. This accounting does not include disclosures for payment, health care operations or certain other purposes, or disclosures to you or with your authorization. Any such request must be made in writing and must include a time period, not to exceed six (6) years. The Plan is only required to provide an accounting of disclosures made on or after April 14, 2003. If you request an accounting more than once in a 12-month period, the Plan may charge you a reasonable fee.

All requests listed above should be submitted in writing to the County's Chief Privacy Officer (see Contact Information below).

THE PLANS' OBLIGATIONS

The federal privacy regulations require us to keep personal information about you private, to give you notice of our legal duties and privacy practices, and to follow the terms of the notice currently in effect.

THIS NOTICE IS SUBJECT TO CHANGE

We may change the terms of this Notice and our privacy policies at any time. If we do, the new terms and policies will be effective for all of the information that we already have about you, as well as any information that we may receive or hold in the future. Revised Notices will be made available to you in writing as required.

COMPLAINTS

You have a right to file a complaint if you believe your privacy rights have been violated. You may file a complaint by writing to the County's Chief Privacy Officer, General Services Administration, 111 NW 1 Street, Suite 2340, Miami, FL 33128. You may also file a complaint with the Department of Health and Human Services. You will not be penalized for filing a complaint.



Benefits Handbook

<http://enet.miamidade.gov>
www.miamidade.gov/benefits

Information contained herein does not constitute an insurance certificate or policy.
Certificates will be provided to participants following the start of the plan year, if applicable.